TEXAS REGISTER

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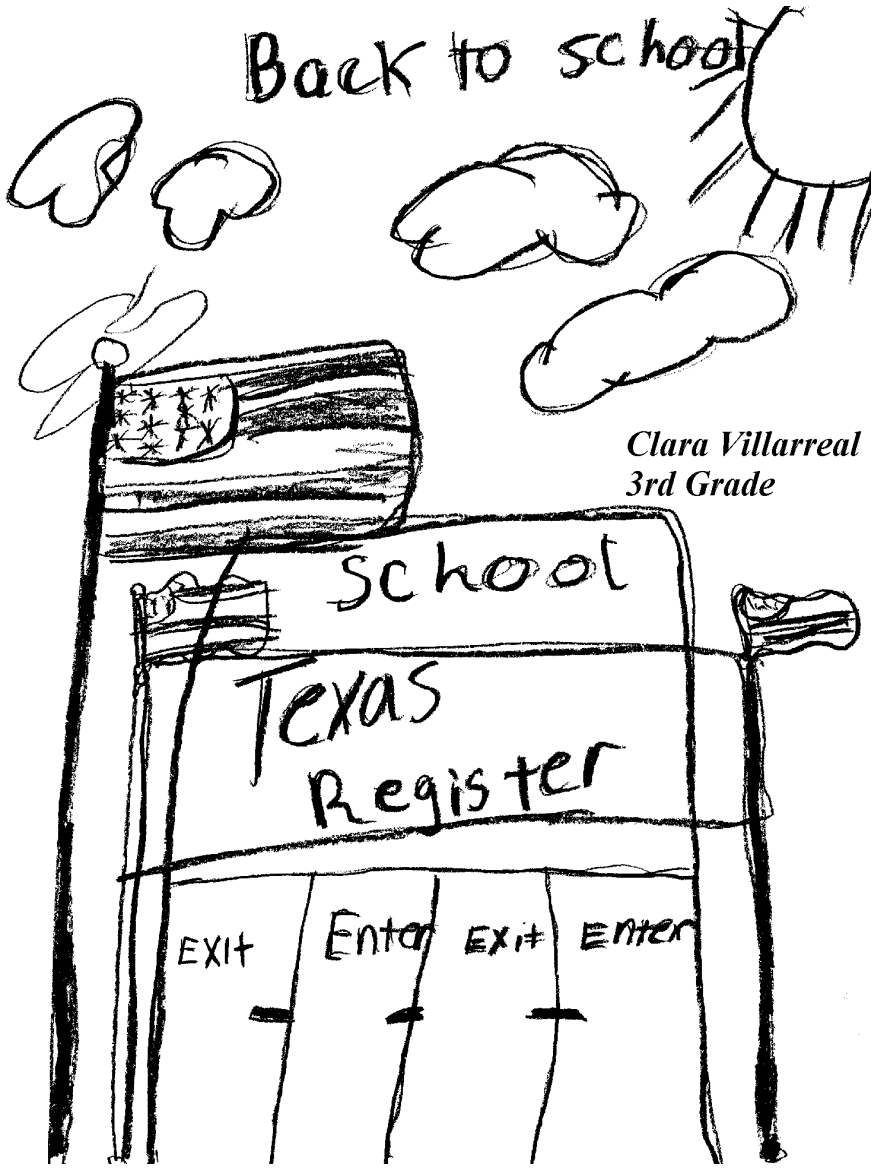

Clara Villarreal
3rd Grade

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

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IN THIS ISSUE

RULE REVIEW

Proposed Rule Reviews

Adopted Rule Reviews

TABLES AND GRAPHICS

IN ADDITION

Office of Consumer Credit Commissioner

East Texas Council of Governments

Texas Commission on Environmental Quality

General Land Office

Texas Department of Health

Texas Health and Human Services Commission

Texas Department of Housing and Community Affairs

Texas Department of Insurance

Legislative Budget Board

Texas Legislative Council

Texas Lottery Commission

Texas Department of Mental Health and Mental Retardation

North Central Texas Council of Governments

Texas State Board of Pharmacy

Public Utility Commission of Texas

Stephen F. Austin State University

Texas A&M University, Board of Regents

Texas Department of Transportation

Open Meetings

A notice of a meeting filed with the Secretary of State by a state governmental body or the governing body of a water district or other district or political subdivision that extends into four or more counties is posted at the main office of the Secretary of State in the lobby of the James Earl Rudder Building, 1019 Brazos, Austin, Texas.

Notices are published in the electronic *Texas Register* and available on-line.
http://www.sos.state.tx.us/texreg

To request a copy of a meeting notice by telephone, please call 463-5561 if calling in Austin. For out-of-town callers our toll-free number is (800) 226-7199. Or fax your request to (512) 463-5569.

Information about the Texas open meetings law is available from the Office of the Attorney General. The web site is http://www.oag.state.tx.us. Or phone the Attorney General's Open Government hotline, (512) 478-OPEN (478-6736).

For on-line links to information about the Texas Legislature, county governments, city governments, and other government information not available here, please refer to this on-line site. http://www.state.tx.us/Government

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Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or Braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting notice several days before the meeting by mail, telephone, or RELAY Texas. TTY: 7-1-1.

THE ATTORNEY GENERAL

Under provisions set out in the Texas Constitution, the Texas Government Code, Title 4, §402.042, and numerous statutes, the attorney general is authorized to write advisory opinions for state and local officials. These advisory opinions are requested by agencies or officials when they are confronted with unique or unusually difficult legal questions. The attorney general also determines, under authority of the Texas Open Records Act, whether information requested for release from governmental agencies may be held from public disclosure. Requests for opinions, opinions, and open records decisions are summarized for publication in the *Texas Register*. The attorney general responds to many requests for opinions and open records decisions with letter opinions. A letter opinion has the same force and effect as a formal Attorney General Opinion, and represents the opinion of the attorney general unless and until it is modified or overruled by a subsequent letter opinion, a formal Attorney General Opinion, or a decision of a court of record. You may view copies of opinions at http://www.oag.state.tx.us. To request copies of opinions, please fax your request to (512) 462-0548 or call (512) 936-1730. To inquire about pending requests for opinions, phone (512) 463-2110.

Request for Opinions

RQ-0253-GA

Requestor:

The Honorable G. E. "Buddy" West

Chair, Committee on Energy Resources

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Authority of the Railroad Commission to use monies from the Oil Field Cleanup Fund to plug oil and gas wells and perform other activities (Request No. 0253-GA)

Briefs requested by September 16, 2004

RQ-0254-GA

Requestor:

The Honorable Bruce Isaacks

Denton County Criminal District Attorney

1450 East McKinney, Suite 3100

Post Office Box 2850

Denton, Texas 76202

Re: Operation of the ex officio road commissioner system and allocation of road and bridge funds in Denton County (Request No. 0254-GA)

Briefs requested by September 16, 2004

RQ-0255-GA

Requestor:

Mr. Gary L. Warren, Sr., Executive Director

Texas Commission on Fire Protection

Post Office Box 2286

Austin, Texas 78768-2286

Re: Whether the Texas Commission on Fire Protection may provide reimbursement for room and board as part of a Fire Department Emergency Fund tuition scholarship for students attending a training school (Request No. 0255-GA)

Briefs requested by September 17, 2004

RQ-0256-GA

Requestor:

The Honorable Frank J. Corte, Jr.

Chair, Committee on Defense Affairs and State-Federal Relations

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether §214.212(c)(1), Local Government Code, which permits a municipality to adopt local amendments to the International Residential Code, limits the municipality to adopting only amendments that are equivalent to or more stringent than the standards of the International Residential Code (Request No. 0256-GA)

Briefs requested by September 18, 2004

RQ-0257-GA

Requestor:

The Honorable Eugene D. Taylor

Williamson County Attorney

Courthouse Annex, Second Floor

405 Martin Luther King, Box 7

Georgetown, Texas 78626

Re: Time of taking office of a person elected to the office of sheriff as a successor to an individual who was appointed to fill a vacancy (Request No. 0257-GA)

Briefs requested by September 18, 2004

RQ-0258-GA

Mr. R. Dyke Rogers, Chairman

Texas Racing Commission

Post Office Box 12080

Austin, Texas 78711-2080

Re: Whether the Racing Commission may grant a license for a race track without a formal certification of election results by the Secretary of State; and whether the Commission may initiate a license application process for a county following a formal certification that occurs more than ten days after the canvass of returns (Request No. 0258-GA)

Briefs requested by September 7, 2004

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200405362
Nancy S. Fuller
Assistant Attorney General
Office of the Attorney General
Filed: August 24, 2004

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Opinions

Opinion No. GA-0233

Mr. Stephen D. Thomas

Executive Director

Texas Residential Construction Commission

Post Office Box 13144

Austin, Texas 78711

Re: Whether the Texas Residential Construction Commission Act excludes from its definition of "builder" businesses and individuals engaged in residential construction and licensed by a municipality, and whether the Texas Residential Construction Commission may seek to enjoin builders who have failed to obtain a certificate of registration from the Commission (RQ-0176-GA)

S U M M A R Y

Section 401.003(c) of the Texas Residential Construction Commission Act does not exclude any business entities or individuals falling within the general definition of "builder" that have a state or local license to engage in residential construction. Section 401.003(c) does except from the definition of "builder" residential construction-related trades and professions, such as plumbers and electricians. Furthermore, section 2001.202 of the Administrative Procedure Act allows the Texas Residential Construction Commission to refer names of builders that have failed to register with the commission, a violation of a commission rule, to the attorney general, who may seek injunctive relief for those violations. The agency is permitted to do this even though its enabling statute lacks specific language to that effect.

Opinion No. GA-0234

The Honorable Ray Allen

Chair, Committee on Corrections

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether, under section 1551.114 of the Insurance Code, an eligible retiree of a community supervision and corrections department may participate in the Employees Retirement System group benefits program after meeting the requirements of subsection (c)(2), with no further requirements, such as the "rule of 80" set out in section 1551.102 (RQ-0213-GA)

S U M M A R Y

In accordance with section 1551.114 of the Insurance Code, a retiree of a community supervision and corrections department may participate in the Employees Retirement System group benefits program after meeting the requirements of section 1551.114(c)(2), with no further requirements, such as the "rule of 80" set out in section 1551.102.

Opinion No. GA-0235

The Honorable Yolanda de Leon

Cameron County District Attorney

Cameron County Courthouse

974 East Harrison Street

Brownsville, Texas 78520

Re: Whether a county may acquire and operate property for the exclusive interment of deceased paupers (RQ-0185-GA)

S U M M A R Y

Pursuant to its duty under Health and Safety Code section 694.002 to provide for the disposition of the body of a deceased pauper, a commissioners court has implied authority to purchase and maintain land for the exclusive interment of deceased paupers. The commissioners court may adopt a rule under this provision authorizing the county to acquire and operate property for this purpose.

Opinion No. GA-0236

Mr. Chris Kloeris

Executive Director

Texas Optometry Board

333 Guadalupe Street, Suite 2-420

Austin, Texas 78701-3942

Re: Whether the Board of Nurse Examiners may permit registered nurses to administer a dangerous drug on the order of a therapeutic optometrist (RQ-0188-GA)

S U M M A R Y

The Board of Nurse Examiners may not permit registered nurses to administer a dangerous drug on the order of a therapeutic optometrist.

For information regarding this publication, please access the website at www.oag.state.tx.us or call the Opinion Committee at 512-463-2110.

TRD-200405368
Nancy S. Fuller
Assistant Attorney General
Office of the Attorney General
Filed: August 24, 2004

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TEXAS ETHICS COMMISSION

The Texas Ethics Commission is authorized by the Government Code, §571.091, to issue advisory opinions in regard to the following statutes: the Government Code, Chapter 302; the Government Code, Chapter 305; the Government Code, Chapter 572; the Election Code, Title 15; the Penal Code, Chapter 36; and the Penal Code, Chapter 39.

Requests for copies of the full text of opinions or questions on particular submissions should be addressed to the Office of the Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, (512) 463-5800.

Advisory Opinion Requests

AOR-513. The Texas Ethics Commission has been asked about the application of the contingent fee prohibition in section 305.022 of the Government Code to a situation in which an individual partner in a limited partnership communicates with a state agency in order to obtain a permit for the limited partnership. The individual partner would not receive any direct compensation for his communications with the state agency, but his stake in the limited partnership would become more valuable if the limited partnership obtained the permit.

AOR-514. The Texas Ethics Commission has been asked to consider the following issues: A. A corporation makes administrative expenditures which include expenditures to fund the incidental costs incurred for carrying out the administrative political purposes of the committee, such as minimal costs incurred for bank charges, the cost of printing checks, and for the time required for the preparation, mailing or delivery of committee contributions. Are these expenditures permissible political expenditures for the administration of the committee? B. Assuming that the costs of the checks, stationery, postage or delivery services and the attendant staff time needed to facilitate and carry out the delivery of a contribution authorized by a general purpose committee are allowable administrative expenditures payable with corporate funds, would the minimal time spent by a corporate employee to deliver a committee check in person at a local campaign event held in the same locale as the employee lives and works during normal working hours similarly be a permissible administrative expense of a corporation?

AOR-515. The Texas Ethics Commission has been asked to consider the following issue: A. A corporation makes certain expenditures to fund the salaries (and related expenses for office equipment, etc used by such personnel in the course of their work) for personnel or payments to non-employee professionals in two separate categories of activity: (1) those employees or non-employee professionals whose functions are administrative in nature and do not include more than minimal incidental involvement in political activities, including secretarial, clerical, administrative, bookkeeping, database management, regulatory compliance (e.g. preparing and filing reports with the Commission) and legal services (when providing legal advice about the administrative activities and regulatory functions of the committee to ensure compliance); and (2) those employees or non-employee professionals who engage in administrative activities such as providing oversight for the committee, setting committee general operating policy, reporting to corporate management on the results of the committee's decisions and participating in meetings related to the daily politically related administrative activities, operations and regulatory functions of the committee, including time spent planning and compiling research for committee meetings and deliberations and recording committee decisions and preparing checks for distribution based on those decisions.

Would the corporation's expenditures in the above two examples of activity be authorized legal corporate administrative expenditures?

B. As a result of the committee's deliberations, corporate employees assigned to the committee compile a report listing, but not advocating for the election of candidates, to whom the committee has contributed. If this report were prepared administratively to reflect the activity of the committee, would this list be an acceptable communication to send to corporate officers and committee members if it is not part of a solicitation? Would the time spent by employees and corporate resources consumed in the preparation and compilation of this report be considered a permissible administrative expenses?

AOR-516. The Texas Ethics Commission has been asked to consider the following issue: A corporation makes expenditures to fund the meetings of a related general purpose committee when that committee meets to evaluate and make determinations as to which candidates to support with committee funds. In this instance, only committee board members and administrative staff are present in the meeting, and no candidates or their agents or outside consultants are present. The expenditures made include the contribution of the time spent by the corporate administrative staff, as well as for the time spent for corporate employees who are members of the committee board. Other expenditures include the use of space, equipment, supplies and the provision of food and beverages.

Are the expenditures made in this instance permissible administrative expenditures that may be paid by the corporation under Section 253.100(a)?

The Texas Ethics Commission is authorized by section 571.091 of the Government Code to issue advisory opinions in regard to the following statutes: (1) Chapter 572, Government Code; (2) Chapter 302, Government Code; (3) Chapter 303, Government Code; (4) Chapter 305, Government Code; (5) Chapter 2004, Government Code; (6) Title 15, Election Code; (7) Chapter 36, Penal Code; and (8) Chapter 39, Penal Code.

Questions on particular submissions should be addressed to the Texas Ethics Commission, P.O. Box 12070, Capitol Station, Austin, Texas 78711-2070, (512) 463-5800.

TRD-200405261
Sarah Woelk
Acting Executive Director
Texas Ethics Commission
Filed: August 20, 2004

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EMERGENCY RULES

Emergency Rules include new rules, amendments to existing rules, and the repeals of existing rules. A state agency may adopt an emergency rule without prior notice or hearing if the agency finds that an imminent peril to the public health, safety, or welfare, or a requirement of state or federal law, requires adoption of a rule on fewer than 30 days' notice. An emergency rule may be effective for not longer than 120 days and may be renewed once for not longer than 60 days (Government Code, §2001.034). An emergency rule may be effective for not longer than 120 days and may be renewed once for not longer than 60 days. (Government Code, §2001.034).

TITLE 19. EDUCATION

PART 7. STATE BOARD FOR EDUCATOR CERTIFICATION

CHAPTER 230. PROFESSIONAL EDUCATOR PREPARATION AND CERTIFICATION

SUBCHAPTER N. CERTIFICATE ISSUANCE PROCEDURES

19 TAC §230.438

The State Board for Educator Certification is renewing the effectiveness of the emergency adoption of new §230.438, for a 60-day period. The text of new §230.438 was originally published in the May 14, 2004, issue of the *Texas Register* (29 TexReg 4629).

Filed with the Office of the Secretary of State, on August 19, 2004.

TRD-200405240
Herman L. Smith, Ph.D.
Executive Director
State Board for Educator Certification
Effective date: August 29, 2004
Expiration date: October 27, 2004
For further information, please call: (512) 936-8304

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PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 17. MARKETING AND PROMOTION

SUBCHAPTER A. TEXAS COMMODITY REFERENDUM ACT

The Texas Department of Agriculture (the department) proposes the repeal of Chapter 17, Subchapter A, §17.20, and proposes new Chapter 17, Subchapter A, Division 1, §17.10, concerning the department's Texas commodity referendum law general program rules. In addition, the department proposes new Chapter 17, Subchapter A, Division 2, §§17.20 - 17.25, concerning the Texas Beef Checkoff Program rules. The department is proposing the repeal of §17.20 and renumbering that section as new Division 1, §17.10. No changes have been made to the section. Existing §§17.1 - 17.9 will also be included in Division 1, General Rules. New Division 2, §§17.20 - 17.25, establish requirements for conducting a beef checkoff referendum and collection of a beef producer assessment, and set out duties of the Texas Beef Council, in accordance with changes made to the Texas Agriculture Code, Chapter 41, by HB 7, enacted by the 78 Legislature, 3rd Special Session, 2003 (HB 7). HB 7 established Chapter 41, Subchapter H, §§41.151 - 41.164, relating to Texas Beef Marketing, Education, Research and Promotion.

Brian Murray, special assistant for producer relations has determined that for the first five-year period the proposed repeal and new sections are in effect there will not be fiscal implications for state or local government as a result of enforcing or administering the sections. Costs of conducting a beef referendum under new Division 2 rules will be borne by the Texas Beef Council.

Mr. Murray has also determined that for each year of the first five years the proposed repeal and new sections are in effect, the public benefit anticipated as a result of administering and enforcing the new sections will be the establishment of a beef checkoff program in Texas, which will allow beef producers to fund programs of promotion, marketing, research, and educational efforts regarding beef and beef products. There is no cost anticipated to micro- businesses, small businesses or individuals required to comply with the new sections.

Comments may be submitted to Brian Murray, Special Assistant for Producer Relations, P.O. Box 12847, Austin, Texas 78711. Comments must be received no later than 30 days from the date of publication of the proposal in the *Texas Register*.

DIVISION 1. GENERAL RULES

4 TAC §17.10

New §17.10 is proposed under the Texas Agriculture Code, §12.016, which authorizes the department to adopt rules to administer its duties under the Code.

The code that will be affected by this proposal is the Texas Agriculture Code, Chapter 12 and Chapter 41.

§17.10. Restrictions on Use of Producer Assessments.

(a) General statement. Except as otherwise provided in this section, funds assessed or collected by a commodity producer board organized under the Texas Commodity Referendum Act, the Texas Agriculture Code, Chapter 41 (the Act), may not be expended to directly or indirectly promote or oppose the election of any candidate for public office or to influence legislation.

(b) Actions to influence legislation. Except as otherwise provided in this section, the term "influence legislation" includes, but is not limited to:

(1) any attempt to affect the opinions of the general public or any segment thereof regarding pending or anticipated legislation;

(2) communication with any member or employee of a legislative body, or with any government official or employee who may participate in the formulation of pending or anticipated legislation;

(3) contacting or urging the public or producers of the commodity covered by the board to contact members of a legislative body for the purpose of proposing, supporting, or opposing legislation;

(4) actively advocating the adoption or rejection of legislation by filing formal comments in support of or in opposition to pending or anticipated legislation; or

(5) any communication with members made for the purpose of encouraging members or producers to do any of the actions identified in paragraphs (1)-(4) of this subsection.

(c) Actions not influencing legislation. The term "influence legislation" does not include the following:

(1) the development and recommendation to the legislature of amendments to the Act;

(2) communication to appropriate government officials of information relating to the conduct, implementation, or results of promotion, research, consumer information, or industry information activities under the Act;

(3) any action designed to market a commodity or commodity products directly to a foreign government or political subdivision thereof;

(4) making available to the public or producers the results of nonpartisan analysis, study, or research;

(5) providing technical advice or assistance (where such advice would otherwise constitute the influencing of legislation) to a governmental body or to a committee or other subdivision thereof, including appearances before any such body, committee or subdivision, in response to a request by such body, committee or subdivision, as the case may be;

(6) appearances before, or communications to, any legislative body with respect to a possible decision of such body which might affect the existence of the organization, its powers and duties or tax-exempt status;

(7) communications between the board and producers of the commodity represented by the board with respect to legislation or proposed legislation of direct interest to the organization and such producers, other than communications described in subsection (b) of this section;

(8) any communication with a government official or employee, other than a communication with a member or employee of a legislative body where such communication would otherwise constitute the influencing of legislation; and

(9) publication of newsletter articles regarding pending legislative issues of interest to members or producers which contain neutral, factual reports.

(d) Promoting or opposing election of candidates for public office. Activities that constitute promoting or opposing election of candidates for public office include, but are not limited to, the publication or distribution of written or printed statements or the making of oral statements on behalf of or in opposition to such a candidate.

(e) Prohibition against indirect funding of actions to influence legislation or promoting or opposing the election of candidates for public office.

(1) Entities and individuals receiving funding from a commodity board organized under the Act shall not use any such funds to influence legislation, as defined in this section, or for supporting or opposing election of a candidate for public office.

(2) Producer assessments may not be used to fund research whose results are to be utilized solely to influence legislation, as that term is defined in this section.

(f) Definition of "legislation." The term "legislation" as used in this section includes action with respect to Acts, bills, resolutions, or similar items by the Congress, any state legislature, any local council, or similar governing body, or by the public in a constitutional amendment or other similar procedure, including Acts providing appropriations to state or federal entities.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 19, 2004.

TRD-200405256
Dolores Alvarado Hibbs
Deputy General Counsel
Texas Department of Agriculture
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-4075

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4 TAC §17.20

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Agriculture or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal of §17.20 is proposed under the Texas Agriculture Code, §12.016, which authorizes the department to adopt rules to administer its duties under the Code.

The code that will be affected by this proposal is the Texas Agriculture Code, Chapter 12 and Chapter 41.

§17.20. Restrictions on Use of Producer Assessments.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 19, 2004.

TRD-200405257
Dolores Alvarado Hibbs
Deputy General Counsel
Texas Department of Agriculture
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-4075

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DIVISION 2. TEXAS BEEF CHECKOFF PROGRAM

4 TAC §§17.20 - 17.25

New §§17.20 - 17.25 are proposed under the Texas Agriculture Code, §12.016, which authorizes the department to adopt rules to administer its duties under the Code; §41.022, which authorizes the department to adopt rules concerning the conducting of a beef referendum, including rules regulating the form of the ballot, the conduct of the election, and the canvassing and reporting of returns; and §41.163, which authorizes the department to adopt rules to implement Subchapter H, including rules relating to auditing of financial records of the beef council, fidelity bonds required for council employees, conflicts of interest, penalties, and conducting of a statewide beef referendum.

The code that will be affected by this proposal is the Texas Agriculture Code, Chapter 12 and Chapter 41.

§17.20. Scope and Applicability.

Except where exempted by this Division, or by the Texas Agriculture Code Chapter 41, as amended by HB 7, enacted by the 78 Legislature, 3rd Special Session, 2003 (HB 7), Chapter 17, Subchapter A, Division 1, governs the Texas Beef Check-off referendum program. This division controls in case of conflict with other sections of this subchapter.

§17.21. Definitions.

In addition to the definitions set forth in the Texas Agriculture Code, Chapter 41, as amended by HB 7, the following words and terms, when used in this Division, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Board--The board of directors of the Texas Beef Council as established by Texas Agriculture Code, Chapter 41, as amended by HB 7;

(2) Cattle--Live domesticated bovine animals regardless of age;

(3) Collecting Person--The person making payment to a producer for cattle, or any other person who is responsible for collecting and remitting an assessment pursuant to Chapter 41 and prescribed by the Board and approved by the Commissioner;

(4) Commissioner--The commissioner of agriculture;

(5) Council--The Texas Beef Council;

(6) Department--The Texas Department of Agriculture;

(7) Mail Balloting--Procedure in which ballots are mailed to eligible producers and then returned to the department with producers' indication of vote and signature indicating voter eligibility as a bona fide producer;

(8) Physical Balloting--A designated location determined by the commissioner where an eligible producer may vote in person; and

(9) Producer--Any person who owns or acquires ownership of cattle; provided, however, that a person shall not be considered a producer within the meaning of this subchapter if:

(A) the person's only share in the proceeds of a sale of cattle or beef is a sales commission, handling fee, or other service fee; or

(B) the person:

(i) acquired ownership of cattle to facilitate the transfer of ownership of such cattle from the seller to a third party;

(ii) resold such cattle no later than ten days from the date on which the person acquired ownership; and

(iii) certified, as required by procedures prescribed by the council, that the requirements of this provision have been satisfied.

§17.22. Voter Eligibility.

A cattle producer, as defined in §17.21 of this title (relating to Definitions), who has owned cattle in the last 12 months before the date of the referendum is eligible to vote in a referendum conducted under these rules.

§17.23. Conduct of Elections; Ballots; Canvass; Voter Eligibility.

(a) Upon request of the Texas Beef Council, the Commissioner shall conduct a referendum as authorized under the Texas Agricultural Code, Chapter 41, as amended.

(b) The commissioner shall propose in a referendum the:

(1) maximum assessment to be paid by cattle producers; and

(2) the manner in which the assessment will be collected.

(c) With the commissioner's approval, the council may set the assessment at a level less than the maximum assessment approved by the referendum.

(d) Legal notice must be published 60 days prior to the election in as many newspapers as are required to achieve general circulation of the notice throughout the state. The notice shall be published not less than once a week for three consecutive weeks. In addition, at least sixty days before the date of the election, the department will give direct written notice to each county cooperative extension office in the state.

(e) Notice provided in accordance with subsection (d) of this section shall include:

(1) the date of the referendum;

(2) the manner in which the referendum is to be conducted and the assessment collected;

(3) the purpose of the referendum;

(4) if an assessment referendum is being conducted, the maximum assessment to be paid by cattle producers; and

(5) who to contact for more information.

(f) An eligible producer may vote only once in a referendum and each vote is of equal weight.

(g) A referendum is approved if a simple majority of votes cast are cast in favor of the referendum.

(h) All voter information, including an individual's vote in a referendum conducted under this section, is confidential and not subject to disclosure under Chapter 552, Government Code.

(i) Ballots must bear the signature and the address of the producer to be valid. A producer's signature on the ballot certifies that the voter owned cattle in the last 12 months before the date of the referendum.

(j) Ballots in all propositions and elections will be counted in a manner determined by the commissioner by a canvassing committee(s) appointed by the commissioner.

(k) The canvassing committee(s) shall verify the election results to the commissioner for certification. Election results will be certified by the commissioner.

(l) Whereas the closed stored container containing referendum ballots cannot be opened during a 45 day period without a court order, any contest of the election or investigation must be filed in the appropriate district court within 30 days of certification of election results by the commissioner.

(m) The department will be reimbursed by the statutorily designated entity (Texas Beef Council) for all costs associated with conducting a referendum under this subchapter.

(n) A referendum conducted under the Texas Agriculture Code, Chapter 41, Subchapter H, as amended by HB 7, 78th Leg., 3rd C.S., and these rules may be conducted by mail or physical ballot.

(o) If conducted by physical balloting:

(1) designated balloting locations must be open at hours prescribed by the commissioner and an election official must be present at all times unless otherwise prescribed by the commissioner. Ballot boxes must be locked and remain unopened until the canvassing committee supervises such opening;

(2) early voting at designated balloting locations will be available to eligible producers;

(3) an eligible voter who is unable to access a designated location for physical balloting may request a mail ballot by contacting the department headquarters or other governmental offices designated by the department. No person requesting a mail ballot who verifies eligibility to vote shall be refused a ballot;

(4) ballots shall be locked in a container and stored with the county clerk's office in the counties designated by the commissioner. If no contests or investigations arise out of the election within 45 days after certification of such election, the clerk shall destroy by shredding or burning and notify the commissioner by mail; and

(5) in any case, if a recount is allowed by the district judge hearing the case, the judge shall have the authority to impound said locked ballot boxes and require a re- canvassing of ballots.

(p) If conducted by mail balloting:

(1) mail ballots must be returned by mail to the principal headquarters of the department. Ballots shall be sent with prepaid return postage;

(2) no mail ballot will be valid if postmarked after midnight on the last day for voting in the referendum or referenda; and

(3) mail ballots submitted to the department shall be maintained at department headquarters located in Austin, Texas. If no contests or investigations arise out of the election within 45 days after certification of such election, the commissioner shall destroy the ballots by shredding or burning.

§17.24. Council Duties; Reporting Requirements.

(a) The council shall have an annual independent audit of the books, records of account and minutes of proceedings maintained by the council prepared by an independent certified public accountant or firm of independent certified public accountants. The audit shall be filed with the council, the commissioner and shall be made available to the public by the council or the commissioner. The state auditor or the department may examine any work papers from the independent audit or may audit the transactions of the council if the state auditor or the department's internal auditor determines that an additional audit is necessary.

(b) Not later than the thirtieth day after the last day of the fiscal year the council shall submit to the commissioner a report itemizing all income and expenditures and describing all activities of the council during the preceding fiscal year. The annual report shall include, at a minimum:

(1) a balance sheet of assets and liabilities;

(2) an itemization of income/expenditures;

(3) a statement of council activities carried out in the year covered by the report; and

(4) copies of any resolutions adopted by the council regarding the program.

(c) The council shall provide fidelity bonds in amounts determined by the council for employees or agents who handle funds for the council.

(d) Prior to any expenditure of funds, the council shall submit its annual budget to the commissioner for approval. The department shall act on the council's budget submission within 45 days of the department's receipt of the submission.

§17.25. Collection of Assessment; Refunds.

(a) The collecting person at a process point determined by the board shall collect the assessment. Except as provided by subsection (b) of this section, the collecting person at that point shall collect the assessment by deducting the appropriate amount from the purchase price of the cattle or from any funds advanced for that purpose.

(b) If the producer and collecting person are the same legal entity, or if the producer retains ownership after processing, the collecting person shall collect the assessment directly from the producer at the time of processing/sale.

(c) The secretary-treasurer of the board, by registered or certified mail, shall notify each known collecting person of the duty to collect the assessment, the manner in which the assessment is to be collected, and the date on or after which the collecting person is to begin collecting the assessment.

(d) The amount of the assessment collected shall be clearly shown on the sales invoice or other document evidencing the transaction. The collecting person shall furnish a copy of the document to the producer.

(e) Unless otherwise provided by the original referendum, no later than the 10th day of each month, the collecting person shall remit the amount collected during the previous month to the secretary-treasurer of the board, along with a completed form prescribed by the board reflecting such amount.

(f) A producer who has paid an assessment may obtain a refund of the amount paid by filing an application for refund with the secretary-treasurer within 60 days after the date of payment. The application must be in writing, on a form prescribed by the board for that purpose, and accompanied by proof of payment of the assessment.

(g) Providing that the assessment has been remitted to the board by the collecting person, the secretary-treasurer shall pay the refund to the producer before the 11th day of the month following the month in which the application for refund and proof of payment are received.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 19, 2004.

TRD-200405255
Dolores Alvarado Hibbs
Deputy General Counsel
Texas Department of Agriculture
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-4075

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TITLE 16. ECONOMIC REGULATION

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 57. FOR-PROFIT LEGAL SERVICE CONTRACT COMPANIES

16 TAC §57.80

The Texas Department of Licensing and Regulation ("Department") proposes an amendment to 16 Texas Administrative Code, §57.80, regarding the for-profit legal service contract companies program.

The amendment proposes to lower the original and renewal registration fee for a sales representative from $50 to $30. Texas Occupations Code, §51.202 requires the Department to set fees in amounts reasonable and necessary to cover the costs of administering programs under its jurisdiction. The Department conducted its annual fee review pursuant to §51.202 and recommended to the Texas Commission of Licensing and Regulation ("Commission") that the referenced fees be reduced as indicated. The revenue generated by current fees exceeds the amount required by the Department to cover costs of administering the for-profit legal service contract companies program. On August 9, 2004, the Commission directed the Department to initiate the recommended fee reductions.

William H. Kuntz, Jr., Executive Director, has determined that for the first five-year period the proposed amendment is in effect there will be no cost to state or local government as a result of enforcing or administering the amended section.

Mr. Kuntz also has determined that for each year of the first five-year period the amendment is in effect, the public benefit will be lower per registration costs.

The Department anticipates decreased economic costs to licensees, small businesses, micro-businesses, or other persons who are required to comply with the amendment as proposed because of the proposed fee reductions.

Comments on the proposal may be submitted to William H. Kuntz, Jr., Executive Director, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or facsimile (512) 475-3032, or electronically: whkuntz@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register*.

The amendment is proposed under Texas Occupations Code, Chapter 953 and Chapter 51, §§51.201, 51.202, and 51.203 which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department and which requires the Commission to set fees in amounts reasonable and necessary to cover the costs of administering Department programs.

The statutory provisions affected by the proposal are those set forth in Texas Occupations Code, Chapter 953 and Chapter 51. No other statutes, articles, or codes are affected by the proposal.

§57.80. Fees.

(a) - (d) (No change.)

(e) The original and renewal registration fee for a sales representative is $30 [~~$50~~].

(f) - (h) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 20, 2004.

TRD-200405274
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-7348

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CHAPTER 67. AUCTIONEERS

16 TAC §67.80, §67.81

The Texas Department of Licensing and Regulation ("Department") proposes amendments to 16 Texas Administrative Code, §67.80 and §67.81, regarding the auctioneer program.

The amendments to §67.80 propose to lower the original auctioneer license fee from $100 to $50 and the associate auctioneer license fee from $50 to $25. The amendments to §67.81 propose to lower the auctioneer renewal fee from $100 to $50 and the associate auctioneer renewal fee from $50 to $25. Texas Occupations Code, §51.202 requires the Department to set fees in amounts reasonable and necessary to cover the costs of administering programs under its jurisdiction. The Department conducted its annual fee review pursuant to §51.202 and recommended to the Texas Commission of Licensing and Regulation ("Commission") that the referenced fees be reduced as indicated. The revenue generated by current fees exceeds the amount required by the Department to cover costs of administering the auctioneer program. On August 9, 2004, the Commission directed the Department to initiate the recommended fee reductions.

William H. Kuntz, Jr., Executive Director, has determined that for the first five-year period the proposed amendments are in effect there will be no cost to state or local government as a result of enforcing or administering the amended sections.

Mr. Kuntz also has determined that for each year of the first five-year period the amendments are in effect, the public benefit will be lower per license costs.

The Department anticipates decreased economic costs to licensees, small businesses, micro-businesses, or other persons who are required to comply with the amendments as proposed because of the proposed fee reductions.

Comments on the proposal may be submitted to William H. Kuntz, Jr., Executive Director, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or facsimile (512) 475-3032, or electronically: whkuntz@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register*.

The amendments are proposed under Texas Occupations Code, Chapter 1802 and Chapter 51, §§51.201, 51.202, and 51.203 which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department and which requires the Commission to set fees in amounts reasonable and necessary to cover the costs of administering Department programs.

The statutory provisions affected by the proposal are those set forth in Texas Occupations Code, Chapter 1802 and Chapter 51. No other statutes, articles, or codes are affected by the proposal.

§67.80. Fees--Original License.

(a) The fee for an auctioneer license is $50 [~~$100~~].

(b) The fee for an associate auctioneer license is $25 [~~$50~~].

§67.81. Fees--Renewal.

(a) The annual fee for renewing an auctioneer license is $50 [~~$100~~].

(b) The annual fee for renewing an associate auctioneer license is $25 [~~$50~~].

(c) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 20, 2004.

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William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-7348

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CHAPTER 68. ARCHITECTURAL BARRIERS

16 TAC §§68.1, 68.10, 68.20, 68.30, 68.31, 68.50 - 68.54, 68.65, 68.70, 68.74 - 68.76, 68.79, 68.80, 68.90, 68.93, 68.100 - 68.103

The Texas Department of Licensing and Regulation ("Department") proposes amendments to existing rules at 16 Texas Administrative Code, §§68.1, 68.10, 68.20, 68.30, 68.31, 68.50, 68.51, 68.52, 68.53, 68.54, 68.65, 68.70, 68.74, 68.75, 68.76, 68.79, 68.80, 68.90, 68.93, 68.100, and 68.101 and new rules §§68.102 and 68.103 regarding the architectural barriers program.

The proposed amendments address statutory changes made by Senate Bill 279, 78th Legislature and the codification of the Architectural Barriers statute from Texas Civil Statutes, Article 9102 to Texas Government Code, Chapter 469, made by House Bill 3507, 78th Legislature.

In proposed rule §68.10, definitions have been revised or added to clarify the application of statutory, rule, and technical requirements. They include: adding language to the definition of "commencement of construction" to clarify that the intended reference is to "the date" associated with commencement of construction; adding language to the definition of "construction documents" to clarify that the term includes plans; adding language defining "common use" and "element" to re-iterate the meaning of these terms as they are used and defined in the Texas Accessibility Standards; adding language defining "crosswalk", "curb line", "pedestrian access route", "pedestrian elements", "public right-of-way", and "sidewalk" to clarify the meanings of these terms as they apply to projects in the public right-of-way; adding language to the definition of "designated agent" to stipulate that the owner's agent must be designated in writing; adding language defining "detention and correctional facilities" to clarify types of facilities; adding language defining "employee work area" to clarify types of spaces/areas the department recognizes as an "employee work area"; revising the definition of "facility" to clarify applicability of the Act; and revising the definition of "issue" as it relates to the established practice of the Texas Board of Architectural Examiners and the Texas Society of Architects.

Section 68.20 has been revised and language added to more accurately reflect what is authorized by statute under Texas Government Code, §469.003. Two types of facilities were deleted from the list under §68.20(a) which are, (1) public entities which donated or allowed use of land for buildings/facilities, and (2) those buildings/facilities constructed with private funds with the intent of donating or deeding to a public entity. The department has determined that these categories go beyond what is specifically authorized by statute and that the revised language and proposed deletions more accurately reflect what is authorized by statute. All other proposed changes more accurately reflect statutory language and department procedures, and some portions have been deleted or relocated to avoid redundancy.

Section 68.30 has been modified and specific exemptions added that should allow for increased understanding of the requirements and more accurate application of the standards. The added exemptions only apply to those limited elements, spaces, and areas within subject facilities where the Department has determined that provisions of the Act should not apply because application of the standards would be impractical or irrelevant to the nature, use, or function of the building/facility AND where the Department believes that the exemption would not significantly impair the acquisition of goods and services by persons with disabilities, substantially reduce the potential for employment of persons with disabilities, or knowingly result in a violation of the Americans with Disabilities Act of 1990. The proposed changes also more accurately reflect exemption language drafted by the federal Architectural and Transportation Barriers Compliance Board (Access Board). The language in §68.30(13) was added in accordance with statutory changes of the 78th Texas Legislature which limits the department's authority to consider only those portions of buildings that are non-residential in determining compliance with the standards. The exemption language clarifies that all facilities occupied solely for residential use that are constructed, renovated, or modified, in whole or in part, on or after January 1, 1970, using funds from the state or a county, municipality, or other political subdivision of the state are now exempted from provisions of the Act (specifically full application of the standards).

Proposed changes in §68.31 provide clarification regarding who may submit a variance and what to include in a variance application. The revisions should allow for improved adherence to Departmental procedures regarding variances. Other proposed revisions in §68.31 reflect new references due to internal organizational changes; increase the period of time available to request an appeal; and eliminate the provisions for appeal to the commission, as they will ultimately review these matters during enforcement resolution.

The added language in §68.50 clarifies the owner's statutory obligation under Texas Government Code, §469.102 to ensure plans are submitted to the Department; stipulates 14 calendar days in lieu of 10 business days for completion of the Registration Form; and clarifies that the applicable fees must be submitted with each separate building or facility that is part of a bid package involving multiple facilities.

The revised language in §68.51 clarifies the level of deficiencies that may be included in the conditional review approval; describes what deficiencies must be addressed and when they must be addressed; and clarifies procedures involved in verification of design revisions and re-submittals.

The revised language in proposed rule §68.52 clarifies the procedures involved in the inspection process and specifies that before proceeding with an inspection, prior authorization from the owner is necessary. Revised language in proposed rule §68.65 includes clean-up language related to re-codification and internal organizational changes.

Proposed amendments to §68.76 deletes existing language and clarifies specific rules of conduct related to variances; adds language specifically excluding Registered Accessibility Specialists (RAS) from submitting or preparing a variance for which they have provided review or inspections services; clarifies the Department's policy; and allows for RAS assistance in the variance process. Proposed amendments to §68.79 clarifies that third party contract providers are subject to complaints.

Proposed amendments to §68.80 clarifies what is to be included (and excluded) from the estimated cost of construction; adds a reference to the fee schedule; reduces the two-hour minimum for special inspections to a one-hour minimum; deletes the current late submittal fee schedule and replaces it with a flat fee of $300; and consolidates the "project filing fee" and "inspection filing fee" into one fee and reduces the combined fee from $200 to $175 pursuant to the Department's annual fee review. Other proposed changes to §68.80 clarifies the multiple options available to register projects in which the estimated construction

cost is less than $50,000, including the applicable fees and corresponding services; updates the existing rules to reference the proposed "late project filing" fee, and clarifies that other fees (i.e. for review and inspection) also apply.

Proposed revisions to §68.93 clarifies the Department's process regarding the audit of RAS and responsibilities of the RAS that pertain to inspection and copy of records. It specifically increases the time to make the records available from 10 calendar days to 14 calendar days.

Proposed revisions to §68.101 adds language which clarifies the registrant's requirements to include applicable fees with the state lease registration form and the applicability to both initial lease agreements and renewals; revises language previously contained in §68.20 to better reflect department procedures; and clarify that it is the obligation of the leasing agency to request an evaluation that could possibly exempt some or all of the lease space, or otherwise full compliance with the applicable standards will be required.

New §68.102 adds language to address TAS scoping and application provisions for public right-of-way projects that are subject to the Act; clarifies that the estimated cost of construction and associated fees for projects within the public right-of-way will be based on the costs of the pedestrian elements only; adds language stipulating that the application of TAS shall be limited to only those pedestrian elements being constructed, renovated, modified, or altered as part of the project scope; clarifies that handrails are not required at sidewalks or curb ramps within the public way, however, if provided must comply; establishes that where adjacent roadway running slopes of 5% or greater exist, the pedestrian access route may not exceed the grade established for the roadway, providing an exception if the pedestrian route complies with TAS 4.8 in its entirety; establishes that detectable warnings of 24" depth (in the direction of travel) will be accepted as satisfying the requirements of TAS 4.7.4; and stipulates that non-signalized driveways are not considered hazardous vehicular areas. The anticipated affect of these proposed changes is increased understanding of the TAS requirements (as they pertain to public right-of-ways), increased cooperation from design professionals and owners in achieving compliance, and improved accessibility in the pedestrian access routes within the public right-of-way.

New §68.103 add language allowing specific alternative standards to be accepted as meeting or exceeding the requirements of TAS for detention and correctional facilities. The alternative standards to be recognized are Sections 11 2.3(1) & (2) and Chapter 12 of Title 36 of the CFR, Part 1191 of the Final Rule published in the federal register and drafted by the federal Architectural and Transportation Barriers Compliance Board (Access Board).

David Gonzales, Manager of the Building and Mechanical Section within the Compliance Division, has determined that for the first five-year period the amendments and new rules are in effect there will be a slight decrease in cost to the state as a result of administering the proposed amendments and new rules. The proposed exemptions will reduce the amount of staff time spent considering requests for waiver. There are no fiscal implications to local government as a result of enforcing or administering the proposed amendments and new rules.

Mr. Gonzales also has determined that for each year of the first five-year period the amendments and new rules are in effect, the public benefit will be improved compliance with the Texas Elimination of Architectural Barriers Act, improved accessibility in the public rights-of-way, and improved accessibility in correctional and detention facilities.

There are no anticipated economic costs to licensees, small businesses, micro-businesses, or other persons who are required to comply with the amendments and new rules as proposed.

Comments on the proposal may be submitted to David Gonzales, Manager, Building and Mechanical Section - Compliance Division, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or facsimile (512) 475-2886, or electronically: david.gonzales@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register*.

The amendments and new rules are proposed under Texas Government Code, Chapter 469 and Texas Occupations Code, Chapter 51, which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposal are those set forth in Texas Government Code, Chapter 469 and Texas Occupations Code, Chapter 51. No other statutes, articles, or codes are affected by the proposal.

§68.1. Authority.

These rules are promulgated under the authority of the Elimination of Architectural Barriers Act, Texas Government Code, Chapter 469 [~~Civil Statutes, Article 9102~~] and Texas Occupations Code, Chapter 51.

§68.10. Definitions.

The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Elimination of [~~Texas~~] Architectural Barriers Act, Texas Government Code, Chapter 469 [~~Civil Statutes, Article 9102~~].

(2) Building--Any structure located in the State of Texas that is used and intended for supporting or sheltering any use or occupancy.

(3) Business days--Calendar days, not including Saturdays, Sundays, and legal holidays.

(4) Commencement of Construction--The date of placement [~~Placement~~] of engineering stakes, delivery of lumber or other construction materials to the job site, erection of batter boards, formwork, or other construction related work.

(5) Commissioner--As used in Chapter 469 [~~Article 9102~~] and in this chapter, has the same meaning as Executive Director.

(6) Completion of Construction--That phase of a construction project which results in occupancy or the issuance of a certificate of occupancy.

(7) Construction Documents--Documents used for construction of a building or facility, including working drawings, plans, specifications, addenda, and applicable change orders.

(8) Contract Provider--The state agency or political subdivision under contract with the department to perform plan reviews, inspections, or both.

(9) Common Use--Refers to those interior and exterior rooms, spaces, or elements that are made available for the use of a

restricted group of people (for example, occupants of a homeless shelter, the occupants of an office building, or the guests of such occupants).

(10) Crosswalk--That part of a roadway where motorists are required to yield to pedestrians crossing, as defined by state and local regulations, whether marked or unmarked.

(11) Curb Line--A line that represents the extension of the face of the curb and marks the transition between the sidewalk and the gutter or roadway at a curb ramp or flush landing.

(12) [~~(9)~~] Designated Agent--An individual designated in writing by the owner to act on the owner's behalf.

(13) Detention and Correctional Facilities--Facilities where occupants are under some degree of restraint or restriction for security reasons including, but not limited to, state prisons, county jails, city jails, detention centers, and substance abuse centers.

(14) Element--An architectural or mechanical component of a building, facility, space, or site, e.g., telephone, curb ramp, door, drinking fountain, seating, or water closet.

(15) Employee Work Area--All or any portion of a space designated for employee use only and used only for work. Corridors, toilet rooms, kitchenettes and break rooms are not employee work areas.

(16) [~~(10)~~] Facility--All or any portion of buildings, structures, site improvements, complexes, equipment, roads, walks, passageways, parking lots, or other real property subject to the Act [~~located in the State of Texas~~].

(17) [~~(11)~~] Issue--To mail, [~~or~~] deliver, transmit, or otherwise release plans or specifications to an owner, lessee, contractor, subcontractor, or any other person acting for an owner or lessee for the purpose of construction, applying for a building permit, or obtaining regulatory approval after such plans have been sealed by an architect, interior designer, landscape architect, or engineer. In [~~in~~] the case of a state-funded or other public works project, it is the time at which plans or specifications are [~~for the purpose of~~] publicly posted [~~posting the project~~] for bids, after such plans or specifications have been sealed by an architect, interior designer, landscape architect, or engineer.

[~~(12) Lessee--With respect to state leased or occupied space, the state agency that enters into a contract with a building owner. In instances of free space or where a written contract is non-existent, reference to the lessee shall mean the occupying state agency.~~]

(18) [~~(13)~~] Overall Responsibility-The level of responsibility held by an architect, landscape architect, interior designer, or engineer who prepares construction documents [~~for~~] and coordinates the various aspects of the design of a building or facility.

(19) [~~(14)~~] Owner--The person or persons, company, corporation, authority, commission, board, governmental entity, institution, or any other entity that holds title to the subject building or facility. For purposes under these rules and the Act, an owner may designate an agent.

(20) Pedestrian Access Route--An accessible route for pedestrian use within the public right-of-way.

(21) Pedestrian Elements--Components that make up a pedestrian access route including, but not limited to walking surfaces, ramps, curb ramps, crosswalks, pedestrian overpasses and underpasses, automated pedestrian signals, elevators, and platform lifts.

(22) Public Right-of-Way--The land or property provided for public roadways, usually including the roadway itself and the areas between the roadway and adjacent properties.

(23) [~~(15)~~] Registered Building or Facility--For the purposes of Texas Government Code, §469.102 [~~Article 9102, §5(k)~~], a registered building or facility is a construction project that has been assigned a project registration number by the department.

(24) [~~(16)~~] Registered Accessibility Specialist--An individual who is certified by the department to perform the review functions, inspection functions, or both review and inspection functions of the department.

(25) [~~(17)~~] Religious Organization--An organization that qualifies as a religious organization as provided in [~~Vernon's~~] Texas [~~Statutes and Codes Annotated~~] Tax Code, [~~Title 1, Subtitle C,~~] Chapter 11, §11.20(c).

(26) Renovation, Modification, or Alteration [~~(18) Renovated, Modified, or Altered~~]--Any construction activity, including demolition, involving any part or all of a building or facility. Cosmetic work and normal maintenance do not constitute a renovation, modification, or alteration.

(27) [~~(19)~~] Rules--Title 16, Texas Administrative Code, Chapter 68, the administrative rules of the Texas Department of Licensing and Regulation promulgated pursuant to the Texas Elimination of Architectural Barriers Act.

(28) Sidewalk--That portion of an accessible route that is improved for use by pedestrians and usually paved.

(29) Space--A definable area, such as a room, toilet room, hall, assembly area, entrance, storage room, alcove, courtyard, or lobby.

(30) [~~(20)~~] State Agency--A board, commission, department, office, or other agency of state government.

(31) [~~(21)~~] TAS--The [~~the~~] Texas Accessibility Standards which were adopted by the Commission December 17, 1993 and became effective April 1, 1994.

(32) [~~(22)~~] Variance Application--The formal documentation filed with the department, by which the owner petitions the department to rule on the impracticality of applying one or more of the standards [~~or specifications~~] to a building or facility.

§68.20. Buildings and Facilities Subject to Compliance with the Texas Accessibility Standards.

(a) A building or facility used by the public is subject to compliance with the Texas Accessibility Standards (hereinafter "TAS") if it is constructed, renovated, or modified, in whole or in part, on or after January 1, 1970, using [:]

[~~(1)~~] [~~public~~] funds from the state [~~a municipality~~], county, municipality [~~the state~~], or other [~~any~~] political subdivision of the state [~~are used any time during the construction process;~~]

[~~(2) a municipality, county, the state, or any political subdivision of the state donate land or other use of public lands on which buildings or facilities are constructed with private funds; or~~]

[~~(3) constructed with private funds with the intent of donating or deeding to a public entity~~].

(b) A building or facility [~~Buildings or facilities that are~~] leased for use or occupied, in whole or in part, by the state under a lease or rental agreement entered into on or after January 1, 1972, is subject to the TAS except as modified under §68.101. [~~rented to the state:~~]

[(1) need not be registered with the department for plan review and inspection if the annual lease expense is $12,000 or less.]

[(2) may be exempted from compliance if it is determined by the occupying agency that the space will not be used by the public and that the occasion for employment for persons with disabilities is improbable because of the essential job functions. The agency shall, prior to advertisement for bid, submit to the department for a determination a completed Lease Evaluation Form obtained from the department. If a Lease Evaluation Form is not submitted, compliance with all applicable standards shall be required.]

(c) The following private [entities] buildings and facilities constructed, renovated, or modified on or after January 1, 1992 [are considered public accommodations] and defined as a "public accommodation" by Section 301, Americans with Disabilities Act of 1990 (42 U.S.C. Section 12181), and its subsequent amendments, are subject to the TAS [Act]:

(1) an inn, hotel, motel, or other place of lodging except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such establishment as the residence of such proprietor;

(2) a restaurant, bar, or other establishment serving food or drinks;

(3) a motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment;

(4) an auditorium, convention center, lecture hall, or other place of public gathering;

(5) a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;

(6) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;

(7) a terminal, depot, or other station used for specified public transportation;

(8) a park, zoo, amusement park, or other place of recreation;

(9) a museum, library, gallery, or other place of public display or collection;

(10) a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;

(11) a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and

(12) a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.

(d) Commercial facilities are subject to the Act if they are intended for non-residential use and if their operations will affect commerce. Such application shall not include railroad locomotives, railroad freight cars, railroad cabooses, railroad cars described in the Americans with Disabilities Act (ADA) §242, or covered under the ADA, Title III, railroad rights-of-way, or facilities that are covered or expressly exempted from coverage under the federal Fair Housing Act of 1968.

(e) Buildings or facilities of a religious organization are subject to the Act except for areas exempted under §68.30 of this title [(relating to Exemptions)].

(f) Buildings or facilities not subject to the Act may be registered, reviewed, and/or inspected upon request and payment of the applicable fee(s).

§68.30. Exemptions.

The following buildings, facilities, [or] spaces, or elements are exempt from the provisions of the Act:

(1) *Federal Property*. Buildings or facilities owned, operated, or leased by the federal government;

(2) *Construction Sites*. Structures and [,] sites [, and equipment] directly associated with the actual processes of construction, including, but not limited to, scaffolding, bridging, materials hoists, materials storage, construction trailers, and portable toilet units provided for use exclusively by construction personnel on a construction site;

(3) *Raised [Security] Areas*. Areas raised [Raised areas used] primarily for purposes of security, life safety, or fire safety, including, but not limited to, observation or lookout galleries, prison guard towers, fire towers, or lifeguard stands;

(4) *Limited Access Spaces*. Spaces accessed only by ladders, catwalks, crawl spaces, or very narrow passageways [, or tunnels];

(5) *Machinery [Equipment] Spaces*. Spaces accessed [frequented] primarily by service personnel for maintenance, repair, or occasional [periodic] monitoring of equipment. Machinery [Such] spaces include, but are not limited to, elevator pits, elevator penthouses, mechanical, electrical, or communications equipment rooms, piping or equipment catwalks, water and sewage treatment pump rooms and stations, petroleum and chemical processing and distribution structures, electric substations and transformer vaults, environmental treatment structures, and highway and tunnel utility facilities; [.]

(6) *Single Occupant Structures*. Single occupant structures accessed only by passageways below grade or elevated above standard curb height [grade], including but not limited to, toll booths that are accessed only by underground tunnels; [.]

(7) *Restricted Occupancy Spaces*. Vertical access (elevators and platform lifts) is not required for the second floor of two-story control buildings located within a chemical manufacturing facility where the second floor is restricted to employees and does not contain common areas or employment opportunities not otherwise available in accessible locations within the same building; [.]

(8) *Places Used Primarily for Religious Rituals*. An area within [Within] a building or facility of a religious organization[, an area] used primarily for religious ritual[,] as determined by the owner or occupant. To facilitate the plan review, the owner or occupant shall include a clear designation of such areas with the plans submitted for review. This exemption does not apply to common areas. Examples of common areas include, but are not limited to, the following: parking facilities, accessible routes, walkways, hallways, toilet facilities, entrances, public telephones, drinking fountains, and exits; [.]

(9) *Specific Employee Work Areas*. Dumpster pads/enclosures that are an extension of a larger employee work area; and employee work areas, or portions of employee work areas, that are less than 150 square feet (14m2) in area and elevated 7 inches (178mm) or more above the ground or finish floor where the elevation is essential to the function of the spaces.

(10) *Accessible Routes to Press Boxes.* Press boxes in bleachers that have points of entry at only one level; and free-standing

press boxes that are elevated above grade 12 feet minimum (3660 mm) are not required to be served by an accessible route provided that the aggregate area of all press boxes is 500 sq. feet (46 m2) maximum.

(11) *Elements, Spaces, and Accessible Routes at Fire Stations*. At fire stations, common use spaces and elements accessed exclusively by fire-fighting personnel are only required to be adaptable. Additionally, at multi-level fire stations, levels accessed exclusively by fire-fighting personnel are not required to be served by an accessible route. These exemptions do not apply to the public spaces and elements within these facilities which must comply with all applicable technical requirements and be served by an accessible route;

(12) *Van-Accessible Parking at Garages Constructed Prior to April 1994*. Parking garages where construction was started on or before April 1, 1994, and the existing vertical clearance of the garage is less than 98", are exempted from requirements to have van-accessible parking spaces located within the garage. If additional surface parking is provided, the required van accessible parking spaces shall be located on a surface lot in closest proximity to the accessible public entrance serving the facility; and

(13) *Residential Facilities*. Those portions of apartments, condominiums, townhomes, and single-family dwellings occupied solely for residential use (i.e. limited to residents and their guests).

§68.31. Variance Procedures.

(a) Requests to waive or modify a standard shall be submitted on the Variance Application form prescribed by the department. A separate variance application shall be submitted for each condition within a single building or facility.

(b) Variance applications shall be submitted by the owner or designated agent of the subject building or facility, and shall be accompanied by the applicable fee and any supporting documentation such as photos, cost analysis, and code references.

(c) A denial of a variance application may be appealed to the Director of Compliance [~~Code Review and Inspections~~], or his designee [~~designate~~], in writing within thirty (30) [~~21~~] calendar days from issuance, upon payment of the applicable appeal fee.

(d) A denial of a variance appeal from the Director of Compliance [~~the Code Review and Inspections Division~~] may be appealed to the Executive Director of the Texas Department of Licensing and Regulation, or his designee [~~designate~~], in writing within thirty (30) calendar [~~ten~~] days of notification of the [~~Division Director's~~] Director of Compliance's decision. [~~The decision of the Executive Director may be appealed to the Texas Commission of Licensing and Regulation in writing within ten calendar days of notification of the Executive Director's decision.~~]

(e) When a variance or appeal determination has been made, the owner or designated agent [~~At each stage of the variance process, the party making the request~~] shall be advised in writing of the determination.

§68.50. Submission of Construction Documents.

(a) An architect, interior designer, landscape architect, or engineer with overall responsibility for the design of a building or facility subject to §469.101 [~~subsection 5(j)~~] of the [~~Architectural Barriers~~] Act, shall mail, ship, or hand-deliver the construction documents to the department, a registered accessibility specialist, or a contract provider not later than five (5) business days after the design professional issues the construction documents.

(b) In instances when there is not a design professional with overall responsibility, the owner is responsible for ensuring construction documents are submitted to the department, a registered accessibility specialist, or a contract provider prior to filing an application for building permit or commencement of construction.

(c) [~~(b)~~] An Elimination of Architectural Barriers Project Registration form must be completed for each subject building or facility and submitted along with the applicable fees not later than fourteen (14) calendar days [~~ten (10) business~~] days after the design professional submits [~~issues~~] the construction documents.

(d) [~~(c)~~] In projects involving multiple phases, construction documents pertaining to each phase shall be submitted in accordance with this chapter.

(e) [~~(d)~~] In projects involving "fast-track" construction, partial submittals of construction documents may be made. Construction documents pertaining to each portion of the work shall be submitted in accordance with these rules.

(f) [~~(e)~~] When bid packages involve multiple facilities such as prototypes or other identical facilities, only one set of construction documents need be submitted. An Elimination of Architectural Barriers Project Registration form and applicable fees must be submitted for each separate building and facility. Construction documents noting site adaptations are required for each location.

§68.51. Review of Construction Documents.

(a) After review, the person making the submission will be advised in writing of the results. Construction documents will be approved only when the documents reflect compliance with all applicable accessibility standards , although a conditional [~~. Conditional~~] approval may be granted when it is determined that resubmittals are not warranted. Conditional approvals will refer to all deficiencies [~~items~~] noted during the review which may not require substantial corrective modifications, but must be addressed [~~included~~] in the design and construction of the building or facility.

(b) Construction documents received by the department, a registered accessibility specialist, or a contract provider shall become the property of the department.

(c) When the department, a registered accessibility specialist, or a contract provider requests [~~requires~~] verification of design revisions, such verifications may be made by submission of revised construction documents, change orders, addenda, and letters [~~specifically addressing each revision~~].

(1) Resubmittals received prior to completion of construction will be reviewed. The [~~and the~~] person making the resubmittal will be advised of the results. Resubmittals will be approved only when the resubmittal reflects compliance with all applicable accessibility standards, although a conditional[~~. Conditional~~] approval may be granted when it is determined that additional submittals are not warranted.

(2) Resubmittals received after completion of construction, based on the recorded estimated completion date, may not be reviewed but will become a matter of record.

§68.52. Inspections.

(a) The building or facility owner shall request an inspection from the department, a registered accessibility specialist, or a contract provider no later than thirty (30) calendar days after the completion of construction, renovation, modification, or alteration of the subject building or facility.

(b) Inspections shall be performed during the normal operating hours of the facility [~~owner~~]. Any deviation from normal operating hours shall be at the convenience of the owner.

(c) The department, registered accessibility specialist, or contract provider shall notify the owner of an impending inspection, and obtain the owner's authorization prior [~~approval~~] to proceeding [~~proceed~~] with the inspection.

(d) The owner shall be advised in writing of the results of each inspection.

§68.53. Corrective Modifications Following Inspection.

(a) When corrective modifications to achieve compliance are required, the department, registered accessibility specialist, or contract provider shall:

(1) provide the owner a list of deficiencies and a deadline for completing modifications; and

(2) grant an extension, consistent with established procedures, if satisfactory evidence is presented showing that the time period specified is inadequate to perform the necessary corrections. [~~; and~~]

[~~(3) require written verification of corrective modifications from the owner, as needed.~~]

(b) When corrective modifications to achieve compliance are required, the owner shall provide written verification of the corrective modifications to the department, registered accessibility specialist, or contract provider.

§68.54. Notice of Substantial Compliance.

The Department shall provide a Notice of Substantial Compliance to the owner, after a newly constructed building or facility has had a satisfactory inspection or submitted verification of corrective modifications.

§68.65. Advisory Committee.

(a) The Elimination of [~~purpose of the~~] Architectural Barriers Advisory Committee shall [~~is to~~] review rules and Technical Memoranda relating to the Elimination of Architectural Barriers program and recommend changes in the rules and Technical Memoranda to the Commission [~~and the Executive Director~~].

(b) Recommendations of the committee will be transmitted to the Commission by the Executive Director through the Director of the Compliance [~~Code Review and Inspections~~] Division.

(c) Committee meetings are called by the committee chair or the Commission [~~Executive Director. Meetings in excess of those mandated by the Act may be authorized by the Executive Director~~].

(d) Expenses reimbursed to committee members shall be limited to authorized expenses incurred while on committee business and traveling to and from committee meetings. The least expensive method of travel should be used. [~~Expenses can be reimbursed to committee members only when the legislature has specifically appropriated money for that purpose.~~]

(e) Expenses paid to committee members shall be limited to those allowed by the State of Texas Travel Allowance Guide and the Texas Department of Licensing and Regulation policies governing travel allowances for employees.

(f) The committee shall be composed of building professionals and persons with disabilities who are familiar with architectural barrier problems and solutions. The committee shall be composed of at least nine members. Persons with disabilities must make up a majority of the membership. [~~The committee shall consist of four building professionals and five consumers. A majority of the Committee shall be persons with disabilities.~~] Committee members will serve staggered three-year terms.

§68.70. Registered Accessibility Specialists--Qualifications for Certification.

(a) An applicant seeking departmental certification as a registered accessibility specialist in order to perform plan review services shall meet the following minimum qualifications:

(1) Any one of the following:

(A) a degree in architecture, engineering, interior design, landscape architecture, or equivalent, and a minimum of one year experience related to building planning, accessibility design or review, or equivalent; or

(B) eight years experience related to building planning, accessibility design or review, or equivalent; or

(C) four years experience related to building planning, accessibility design or review, or equivalent, and certification as an accessibility specialist granted by a model building code organization; and

(2) satisfactory completion of the Texas Accessibility Academy offered by the department or an approved provider; and

(3) pass an examination approved by the department.

(b) An applicant seeking departmental certification as a registered accessibility specialist in order to provide inspection services shall meet the following minimum qualifications:

(1) Any one of the following:

(A) minimum of a high school diploma or equivalent; and

(B) either

(i) four years experience related to building inspections, accessibility inspections, building planning, accessibility design or review, or equivalent; or

(ii) two years experience related to building inspections, accessibility inspections, building planning, accessibility design or review, or equivalent, and certification as an accessibility specialist as granted by a model building code organization; and

(2) satisfactory completion of the Texas Accessibility Academy offered by the department or an approved provider; and

(3) pass an examination approved by the department.

(c) An applicant shall submit a complete application for certification on the form prescribed by the department, accompanied by all appropriate fees. An applicant must complete all requirements, including satisfactory completion of an examination, no later than one year after the date the application is filed.

(d) Each applicant who satisfies all requirements will be provided a wallet card. The wallet card is the actual certificate of registration. A wall certificate will be provided to a new registrant.

(e) Endorsement codes for certificates of registration are as follows: Plan review functions--R; Inspection functions--I; Plan review and inspection functions--RI.

§68.74. Registration Requirements--Renewal.

(a) A complete application for registration renewal must be submitted on an approved Department form with all required fees and must be filed by the expiration date, or the registration will expire.

(b) Non-receipt of a registration renewal notice from the Department does not exempt a person from any requirements of this chapter.

(c) A registrant shall not perform work requiring registration under Chapter 469, Texas Government Code, [~~Texas Civil Statutes, Article 9102~~] with an expired registration.

§68.75. Responsibilities of the Registered Accessibility Specialist.

(a) Registered accessibility specialists may set and collect fees for services, but are responsible for submitting to the department any fees the registered accessibility specialist may receive on behalf of the Department.

(b) Records maintained by registered accessibility specialists, as required by department rules or procedures, are subject to the provisions of the Texas Government Code, Chapter 552, Texas Open Records Act.

(c) Registered accessibility specialists [~~endorsed for plan review services~~] shall [~~submit all required fees to the department, and~~] comply with all procedures established by the department relating to plan reviews and inspections.

(d) Registered accessibility specialists [~~endorsed for inspection services~~] shall [~~:~~]

[~~(1)~~] verify the ownership of each building or facility for which they perform review or inspection services [~~, prior to submittal of the inspection;~~]

[~~(2) submit all required fees to the department, and comply with all procedures established by the department relating to inspections~~].

(e) Registered accessibility specialists shall notify the department of changes to contact information including but not limited to name, address, phone number, and e-mail address.

§68.76. Standards of Conduct for the Registered Accessibility Specialist.

(a) *Competency*. The registered accessibility specialist shall be knowledgeable of and adhere to the Act, the rules, the TAS, Technical Memoranda published by the department, and all procedures established by the department for plan reviews and inspections. It is the obligation of the registered accessibility specialist to exercise reasonable judgment and skill in the performance of plan reviews, inspections, and related activities.

(b) *Integrity*. A registered accessibility specialist shall be honest and trustworthy in the performance of plan review, inspection, and related activities, and shall avoid misrepresentation and deceit in any fashion, whether by acts of commission or omission. Acts or practices that constitute threats, coercion, or extortion are prohibited.

(c) *Interest*. The primary interest of the registered accessibility specialist is to ensure compliance with the Act, the rules, and the TAS. The registered accessibility specialist's position, in this respect, should be clear to all parties concerned while conducting plan reviews, inspections, and related activities.

(d) *Conflict of Interest*. A registered accessibility specialist is obliged to avoid conflicts of interest and the appearance of a conflict of interest. A conflict of interest exists when a registered accessibility specialist performs or agrees to perform a plan review, inspection, or related activity for a project in which he/she has a financial interest, whether direct or indirect. A conflict of interest also exists when a registered accessibility specialist's professional judgment and independence are affected by his/her own family, business, property, or other personal interests or relationships.

(e) *Specific Rules of Conduct*. A registered accessibility specialist shall not:

(1) participate, whether individually or in concert with others, in any plan, scheme, or arrangement attempting or having as its purpose the evasion of any provision of the Act, the rules, or the TAS;

(2) knowingly furnish inaccurate, deceitful, or misleading information to the department, a building owner, or other person involved in a plan review, inspection, or related activity;

(3) state or imply [~~to the a building owner~~] that the department will approve [~~grant~~] a variance;

(4) submit or prepare a variance application for a project in which the RAS has provided review or inspection services;

(5) [~~(4)~~] engage in any activity that constitutes dishonesty, misrepresentation, or fraud while performing a plan review, inspection, or related activity;

(6) [~~(5)~~] perform a plan review, inspection, or related activity in a negligent or incompetent manner;

(7) [~~(6)~~] perform a plan review, inspection, or related activity on a building or facility in which the registered accessibility specialist is an owner, either in whole or in part, or an employee of a full or partial owner;

(8) [~~(7)~~] perform a plan review, inspection, or a related activity on a building or facility that is or will be leased or occupied by an agency of the State of Texas, when the registered accessibility specialist is an employee of the state agency that will occupy the facility; or

(9) [~~(8)~~] perform a plan review, inspection, or related activity on a building or facility wherein the registered accessibility specialist, for compensation, participated in creating the overall design of the current project.

§68.79. Contract Providers.

In addition to the specific terms of their contracts, contract providers are subject to the same minimum qualifications, responsibilities, and standards of conduct as registered accessibility specialists. Contract providers are also subject to the same complaint, investigation and audit procedures as registered accessibility specialists.

§68.80. Fees.

(a) Plan review and inspection fees collected by the department shall be determined by the estimated [~~project~~] cost of construction for the project, not including site acquisition, furnishings, or equipment that is not part of the building mechanical systems. Fees will be [~~and~~] assessed according to the fee schedule (see §68.80(b)). In instances involving multiple facilities with identical drawings, but site adapted, and designed by the same individual or firm and bid as one package, the plan review fee shall be based on the total construction cost. However, separate inspection fees shall be required. The plan review fee and project filing fee must accompany the registration form and be submitted with the construction documents. The inspection fee [~~and inspection filing fee~~] must be paid and the department notified of a point of contact within thirty (30) calendar [~~30~~] days of completion of construction.

(b) Fee Schedule:
Figure: 16 TAC §68.80(b)

(c) When the estimated construction cost is less than $50,000, and the project is registered with the department for review, inspection, or for review and inspection, the following shall apply: [~~and a review, inspection or both are requested, a $200 plan review fee and a $200 inspection fee shall be paid.~~]

(1) the project filing fee and a $200 plan review fee shall be paid for registration and review only;

(2) the project filing fee, a $200 plan review fee, and $200 inspection fee shall be paid for registration, review, and inspection; or

(3) the project filing fee and a $200 inspection fee shall be paid for registration and inspection.

(d) All fees must be paid prior to service being performed. All fees are non-refundable.

(e) When a project is registered with the department after completion of construction [~~a subject project~~], the Late Project Filing [~~Submittal~~] Fee and other applicable fees shall apply [~~in lieu of the review fee required by subsection (b) of this section~~].

(f) Late renewal fees for registrations issued under this chapter are provided under §60.83 of this title (relating to Late Renewal Fees).

§68.90. Administrative Sanctions or Penalties.

(a) If a person violates any provision of Texas Government Code, Chapter 469 [~~Title 132A, Texas Civil Statutes, Article 9102~~], any provision of Title 16, Texas Administrative Code, Chapter 68, any provision of the Texas Accessibility Standards (TAS), or an order of the Executive Director or Commission, proceedings may be instituted to impose administrative sanctions, administrative penalties, or both administrative penalties and sanctions in accordance with the provisions of Texas Government Code, Chapter 469 [~~Title 132A, Texas Civil Statutes, Article 9102~~]; Title 2, Texas Occupations Code, Chapter 51; and Title 16, Texas Administrative Code, Chapter 60 of this title (relating to the Texas Department of Licensing and Regulation).

(b) It is a violation of the Act for a person to perform a plan review or inspection function of the department, unless that person is a department employee, a registered accessibility specialist with the appropriate endorsement, or a contract provider. A person who does not hold one of these designations and performs a plan review or inspection function of the department is subject to administrative penalties in accordance with the Act or Title 2, Texas Occupations Code, Chapter 51 and Title 16, Texas Administrative Code, Chapter 60.

(c) Cheating on an examination is grounds for denial, suspension, or revocation of a license, imposition of an administrative penalty, or both.

§68.93. Complaints, Investigations, and Audits.

(a) *Complaints.* A complaint may be filed against an owner if there is reason to believe that a building or facility is not in compliance with the Act, the rules, or the TAS. A complaint may be filed against a registered accessibility specialist if there is reason to believe that the registered accessibility specialist has violated the Act, the rules, or the TAS.

(b) *Investigations and Audits [~~Monitoring~~].* Owners of buildings and facilities subject to compliance with the TAS are subject to investigation by the department. Registered accessibility specialists and contract providers are subject to investigation and audit [~~monitoring~~] by the department.

(c) *Inspection and Copying of Records [~~of Registered Accessibility Specialist~~].* Records [~~A registered accessibility specialist's records,~~] pertaining to a project for which plan review, inspection, or related activities have been or will be performed, shall be made available by the registered accessibility specialist for [~~the~~] inspection and copying by the department. The registered accessibility specialist shall make said records available within fourteen (14) [~~ten (10)~~] calendar days of receiving a written request [~~for records~~] from the department.

§68.100. Technical Standards and Technical Memoranda.

(a) The Texas Department of Licensing and Regulation adopts by reference the Texas Accessibility Standards (TAS), April 1, 1994 edition.

(b) The Texas Department of Licensing and Regulation may from time to time, publish Technical Memoranda to provide clarification of technical matters relating to the Texas Accessibility Standards, if such memoranda have been reviewed by the Elimination of Architectural Barriers Advisory Committee.

§68.101. State Leases [~~(initial or renewed)~~].

(a) State leased buildings or facilities with an annual lease expense in excess of $12,000 shall be registered with the department by completing a State Lease Registration form and submitting it along with the applicable fee(s). This requirement applies to both initial lease agreements and lease renewals. For state leased buildings or facilities that are being newly constructed or substantially renovated, an Elimination of Architectural Barriers Project Registration form shall also be completed.

(b) The agency shall, prior to advertisement for bid, submit to the department for a determination a completed Lease Evaluation Form obtained from the department. If a Lease Evaluation Form is not submitted, compliance with all applicable standards shall be required. State leases may be exempted from compliance if it is determined by the department that the space will not be used by the public and that the occasion for employment for persons with disabilities is improbable because of the essential job functions.

(c) [~~(b)~~] Buildings or facilities that are leased or occupied in whole or in part for use by the state, shall meet the following requirements of TAS:

(1) New construction shall comply with TAS 4.1.2 and 4.1.3.

(2) Additions shall comply with TAS 4.1.5.

(3) Alterations shall comply with TAS 4.1.6.

(4) istoric buildings or facilities shall comply with TAS 4.1.7.

(5) Existing buildings and facilities are ones that have not been constructed, renovated, modified or altered since April 1, 1994. In an existing building or facility, where alterations are not planned or the planned alterations will not affect an area containing a primary function, the following minimum requirements shall apply:

(A) If parking is required as part of the lease agreement or is provided to serve the leased area, accessible parking spaces shall comply with TAS 4.6.

(B) An accessible route from the parking area(s) shall comply with TAS 4.3.

(C) At least one entrance serving the leased space shall comply with TAS 4.14.

(D) If toilet rooms or bathrooms are required by the lease agreement or are provided to serve the leased area, at least one set of men's and women's toilet rooms or bathrooms or at least one unisex toilet room or bathroom serving the leased area shall comply with TAS 4.22 or 4.23.

(E) Signage at toilet rooms or bathrooms shall comply with TAS 4.30. Toilet rooms or bathrooms serving the leased area which are not accessible shall be provided with signage complying with TAS 4.30.1, 4.30.2, 4.30.3, 4.30.5 and 4.30.7, indicating the location of the nearest accessible toilet room or bathroom within the facility.

(F) If drinking fountains are required by the lease agreement, or are provided to serve the leased area, at least one fountain shall comply with TAS 4.15. If more than one drinking fountain is provided, at least 50% shall comply with TAS 4.15.

(G) If public telephones are required by the lease agreement, or are provided to serve the leased area, at least one public telephone shall comply with TAS 4.31.

(H) If an element or space of a lease is not specified in this subsection but is present in a state leasehold, that element or space shall comply with TAS 4.1.6.

§68.102. Public Right-of-Way Projects.

(a) For purposes of §68.80, the estimated cost of construction for the project shall be based on the pedestrian elements only. The construction documents submitted for review would be those pertaining to the pedestrian elements.

(b) Application of TAS shall be limited to those pedestrian elements being constructed, renovated, modified, or altered as part of the project scope. The pedestrian elements shall comply with applicable TAS 4.1 through 4.35 except as modified by this section.

(1) Sidewalks--At sidewalks constructed within the public right-of-way, handrails are not required; however, if provided they must comply with TAS 4.8.5. Where the adjacent roadway has running slopes of 5% or greater, the pedestrian access route shall not exceed the grade established for the adjacent roadway. EXCEPTION: The running slope of a pedestrian access route is permitted to be steeper than the grade of the adjacent roadway provided that the pedestrian access route complies with TAS 4.8.

(2) Curb Ramps--At curb ramps constructed within the public right-of-way, handrails are not required; however, if provided they must comply with TAS 4.8.5.

(A) At perpendicular curb ramps constructed within the public right of way, textures complying with TAS 4.7.4 *or* detectable warnings provided at a minimum of 24" in depth (in the direction of pedestrian travel) and extending the full width of the curb ramp shall be provided.

(B) At parallel curb ramps constructed within the public right-of-way, textures complying with TAS 4.7.4 *or* detectable warnings provided at a minimum of 24" in depth (in the direction of pedestrian travel) and extending the full width of the landing where the pedestrian access route enters crosswalks or other hazardous vehicular areas shall be provided. For purposes of this section, non-signalized driveways are not considered hazardous vehicular areas.

(C) At diagonal curb ramps constructed within the public right-of-way, textures complying with TAS 4.7.4 *or* detectable warnings extending 24" minimum (in the direction of pedestrian travel) and the full width of the curb ramp or landing shall be provided. Additionally, the department will allow the detectable warning to be curved with the radius of the corner. The detectable warning shall be located so that the edge nearest the curb line is 6" minimum and 8" maximum from the curb line.

§68.103. Detention and Correctional Facilities.

For these facilities, in addition to accepting compliance with applicable TAS requirements, the department will also accept compliance with Sections 11.2.3(1) and (2), and Chapter 12, in its entirety, of Title 36, CFR, Part 1191 Final Rule published in the Federal Register January 13, 1998.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 19, 2004.

TRD-200405253
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-7348

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CHAPTER 70. INDUSTRIALIZED HOUSING AND BUILDINGS

16 TAC §70.80

The Texas Department of Licensing and Regulation ("Department") proposes an amendment to 16 Texas Administrative Code, §70.80, regarding the industrialized housing and buildings program.

The amendment proposes to lower the builder's registration fee from $375 to $325. Texas Occupations Code, §51.202 requires the Department to set fees in amounts reasonable and necessary to cover the costs of administering programs under its jurisdiction. The Department conducted its annual fee review pursuant to §51.202 and recommended to the Texas Commission of Licensing and Regulation ("Commission") that the referenced fees be reduced as indicated. The revenue generated by current fees exceeds the amount required by the Department to cover costs of administering the industrialized housing and buildings program. On August 9, 2004, the Commission directed the Department to initiate the recommended fee reductions.

William H. Kuntz, Jr., Executive Director, has determined that for the first five-year period the proposed amendment is in effect there will be no cost to state or local government as a result of enforcing or administering the amended section.

Mr. Kuntz also has determined that for each year of the first five-year period the amendment is in effect, the public benefit will be lower per registration costs.

The Department anticipates decreased economic costs to licensees, small businesses, micro-businesses, or other persons who are required to comply with the amendment as proposed because of the proposed fee reduction.

Comments on the proposal may be submitted to William H. Kuntz, Jr., Executive Director, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or facsimile (512) 475-3032, or electronically: whkuntz@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register*.

The amendment is proposed under Texas Occupations Code, Chapter 1202 and Chapter 51, §§51.201, 51.202, and 51.203 which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department and which requires the Commission to set fees in amounts reasonable and necessary to cover the costs of administering Department programs.

The statutory provisions affected by the proposal are those set forth in Texas Occupations Code, Chapter 1202 and Chapter 51. No other statutes, articles, or codes are affected by the proposal.

§70.80. Commission Fees.

(a) (No change.)

(b) The industrialized builder's registration fee is $325 [~~$375~~] annually.

(c) - (l) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 20, 2004.

TRD-200405272
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-7348

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CHAPTER 75. AIR CONDITIONING AND REFRIGERATION CONTRACTOR LICENSE LAW

16 TAC §75.80

The Texas Department of Licensing and Regulation ("Department") proposes an amendment to 16 Texas Administrative Code, §75.80, regarding the air conditioning and refrigeration contractor licensing program.

The amendment proposes to lower the initial and renewal license fees from $125 to $80. Texas Occupations Code, §51.202 requires the Department to set fees in amounts reasonable and necessary to cover the costs of administering programs under its jurisdiction. The Department conducted its annual fee review pursuant to §51.202 and recommended to the Texas Commission of Licensing and Regulation ("Commission") that the referenced fees be reduced as indicated. The revenue generated by current fees exceeds the amount required by the Department to cover costs of administering the air conditioning and refrigeration contractor licensing program. On August 9, 2004, the Commission directed the Department to initiate the recommended fee reductions.

William H. Kuntz, Jr., Executive Director, has determined that for the first five-year period the proposed amendment is in effect there will be no cost to state or local government as a result of enforcing or administering the amended section.

Mr. Kuntz also has determined that for each year of the first five-year period the amendment is in effect, the public benefit will be lower per license costs.

The Department anticipates decreased economic costs to licensees, small businesses, micro-businesses, or other persons who are required to comply with the amendment as proposed because of the proposed fee reductions.

Comments on the proposal may be submitted to William H. Kuntz, Jr., Executive Director, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or facsimile (512) 475-3032, or electronically: whkuntz@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register*.

The amendment is proposed under Texas Occupations Code, Chapter 1302 and Chapter 51, §§51.201, 51.202, and 51.203 which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department and which requires the Commission to set fees in amounts reasonable and necessary to cover the costs of administering Department programs.

The statutory provisions affected by the proposal are those set forth in Texas Occupations Code, Chapter 1302 and Chapter 51. No other statutes, articles, or codes are affected by the proposal.

§75.80. Fees.

(a) - (b) (No change.)

(c) License fees are:

(1) initial license is $80 [~~$125~~] and

(2) renewal fee is $80 [~~$125~~].

(d) - (g) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 20, 2004.

TRD-200405270
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-7348

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CHAPTER 80. LICENSED COURT INTERPRETERS

16 TAC §80.80

The Texas Department of Licensing and Regulation ("Department") proposes an amendment to 16 Texas Administrative Code, §80.80, regarding the licensed court interpreters program.

The amendment proposes to lower the original application fee from $175 to $75 and to lower the renewal fee from $100 to $50. Texas Occupations Code, §51.202 requires the Department to set fees in amounts reasonable and necessary to cover the costs of administering programs under its jurisdiction. The Department conducted its annual fee review pursuant to §51.202 and recommended to the Texas Commission of Licensing and Regulation ("Commission") that the referenced fees be reduced as indicated. The revenue generated by current fees exceeds the amount required by the Department to cover costs of administering the licensed court interpreters program. On August 9, 2004, the Commission directed the Department to initiate the recommended fee reductions.

William H. Kuntz, Jr., Executive Director, has determined that for the first five-year period the proposed amendment is in effect there will be no cost to state or local government as a result of enforcing or administering the amended section.

Mr. Kuntz also has determined that for each year of the first five-year period the amendment is in effect, the public benefit will be lower per license costs.

The Department anticipates decreased economic costs to licensees, small businesses, micro-businesses, or other persons who are required to comply with the amendment as proposed because of the proposed fee reductions.

Comments on the proposal may be submitted to William H. Kuntz, Jr., Executive Director, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or facsimile (512) 475-3032, or electronically: whkuntz@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register*.

The amendment is proposed under Texas Government Code, Chapter 57 and Texas Occupations Code, Chapter 51, §§51.201, 51.202, and 51.203 which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department and which requires the Commission to set fees in amounts reasonable and necessary to cover the costs of administering Department programs.

The statutory provisions affected by the proposal are those set forth in Texas Government Code, Chapter 57 and Texas Occupations Code, Chapter 51. No other statutes, articles, or codes are affected by the proposal.

§80.80. Fees.

(a) (No change.)

(b) The original license application filing fee shall be $75 [~~$175~~].

(c) The renewal application filing fee shall be $50 [~~$100~~].

(d) - (f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 20, 2004.

TRD-200405273
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 463-7348

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TITLE 22. EXAMINING BOARDS

PART 2. TEXAS STATE BOARD OF BARBER EXAMINERS

CHAPTER 51. PRACTICE AND PROCEDURE

SUBCHAPTER A. THE BOARD

22 TAC §51.3

The Texas State Board of Barber Examiners proposes an amendment to §51.3 concerning fines and administrative penalties for practice violations related to Chapter 1601 of the Texas Occupations Code.

The action is taken to impose fines (penalties) for violation of proposed changes to §51.93 requiring regular, documented procedures for cleaning and sanitizing footspas and to impose fines in place of warnings for the first offense for specific health or sanitation-related violations.

Glenn Parker, Executive Director, has determined that for the first five year period the rule is in effect there will be no fiscal implications for local government as a result of enforcing or administering the rule. There will be an impact to state government in that revenues from fines will increase by less than $5,000 per year.

Mr. Parker has determined that for each year of the first five years the rule is to be in effect, the public benefit anticipated as a result of enforcing the rule will be an increase in the level of protection of the health of the public who use the services provided by board licensees. There will be no direct costs to the general public. There will be an increase in costs to licensees equal to the amount of the fines (penalties) levied against them individually. Other than for fines specific to individuals, there will no cost to small or large businesses, or individuals associated with the enforcement of the proposed rule.

Comments on the proposed rule may be submitted in writing within 30 days after publication of the proposal in the *Texas Register* to Glenn Parker, Executive Director, Texas State Board of Barber Examiners, 5717 Balcones Drive, Suite 217, Austin, Texas 78731-4203.

The amendment is proposed under the Texas Occupations Code Chapter 1601.151 and Chapter 1601.155 which provide the Texas State Board of Barber Examiners with the authority to adopt and enforce all rules necessary for the performance of its duties and to set fees in amounts necessary to cover the costs of administering the programs to which fees relate.

§51.3. Administrative Fines.

(a) (No change.)

(b) Fine schedule:
Figure: 22 TAC §51.3(b)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 16, 2004.

TRD-200405177
Glenn D. Parker
Executive Director
Texas State Board of Barber Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 936-6333

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PART 9. TEXAS STATE BOARD OF MEDICAL EXAMINERS

CHAPTER 163. LICENSURE

The Texas State Board of Medical Examiners proposes amendments to §§163.1 - 163.3, 163.5, 163.6 and the repeal of §163.8 and §163.9, concerning Definitions, Licensure for United States/Canadian Medical School Graduates, Licensure for Graduates of Acceptable Unapproved Medical Schools,

Licensure Documentation, and Examinations Accepted for Licensure.

The amendments and repeal are necessary to reflect changes to jurisprudence examination, interpretation of medical school education, and definitions of practice of medicine.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners contemporaneously withdraws the proposed amendment to §163.1 which appeared in the May 14, 2004, issue of the *Texas Register* (29 TexReg 4718).

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the amendments and repeal are in effect there will be no fiscal implications to state or local government as a result of enforcing the amendments and repeal as proposed. There will be no effect to individuals required to comply with the amendments and repeal as proposed.

Ms. Shackelford also has determined that for each year of the first five years the amendments and repeal as proposed are in effect the public benefit anticipated as a result of enforcing the amendments and repeal will be updated rules concerning licensure. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018. A public hearing will be held at a later date.

22 TAC §§163.1 - 163.3, 163.5, 163.6

The amendments are proposed under the authority of the Occupations Code Annotated, §§151.002, 151.056, 155.001, 155.002, 155.003, 155.0031, 155.004, 155.005, 155.007, 155.008, 155.051, 155.0511, 155.052, 155.053, 155.054, 155.055, 155.056, 155.057, 155.058, and 155.104 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§163.1. Definitions.

(a) The following words and terms, (concerning General Definitions) when used in this chapter, shall have the following meanings, unless the context clearly indicates [~~indicate~~] otherwise.

(1) Acceptable approved medical school--A medical school or college located in the United States or Canada that has been accredited by the Liaison Committee on Medical Education or the American Osteopathic Association Bureau of Professional Education.

(2) Acceptable unapproved medical school--A school or college located outside the United States or Canada that:

(A) is substantially equivalent to a Texas medical school; and

(B) has not been disapproved by another state physician licensing agency unless the applicant can provide evidence that the disapproval was unfounded.

(3) Affiliated hospital--Affiliation status of a hospital with a medical school as defined by the Liaison Committee on Medical Education and documented by the medical school in its application for accreditation.

(4) Applicant--One who files an application as defined in this section.

(5) Application--An application is all documents and information necessary to complete an applicant's request for licensure including the following:

(A) forms furnished by the board, completed by the applicant:

(i) all forms and addenda requiring a written response must be typed or printed in ink;

(ii) photographs must meet United States Government passport standards;

(B) all documents required under section 163.5 of this title (relating to Licensure Documentation); and

(C) the required fee, payable by check through a United States bank.

(6) Board--Texas State Board of Medical Examiners

(7) Continuous--12 month periods of uninterrupted postgraduate training with no absences greater than 21 days, unless such absences have been approved by the training program.

(8) Eligible for licensure in country of graduation--An applicant must be eligible for licensure in the country in which the medical school is located except for any citizenship requirements.

(9) Examinations accepted by the board for licensure.

(A) United States Medical Licensing Examination (USMLE), with a score of 75 or better, or a passing grade if applicable, on each step, with all steps passed within seven years;

(B) Federation Licensing Examination (FLEX), on or after July 1, 1985, passage of both components within seven years with a score of 75 or better on each component;

(C) Federation Licensing Examination (FLEX), before July 1, 1985, with a FLEX weighted average of 75 or better in one sitting;

(D) National Board of Medical Examiners Examination (NBME) or its successor with all steps passed within seven years;

(E) National Board of Osteopathic Medical Examiners Examination (NBOME) or its successor with all steps passed within seven years;

(F) Medical Council of Canada Examination (LMCC) or its successor, with all steps passed within seven years;

(G) State board licensing examination, passed before January 1, 1977, (with the exception of Virgin Islands, Guam, Tennessee Osteopathic Board or Puerto Rico then the exams must be passed before July 1, 1963); or

(H) One of the following examination combinations with a score of 75 or better on each part, level, component, or step, all parts, levels, components, or steps must be passed within seven years:

(i) FLEX I plus USMLE 3;

(ii) USMLE 1 and USMLE 2 (including passage of the clinical skills component if applicable), plus FLEX II;

(iii) NBME I or USMLE 1, plus NBME II or USMLE 2 (including passage of the clinical skills component if applicable), plus NBME III or USMLE 3;

(iv) NBME I or USMLE 1, plus NBME II or USMLE 2 (including passage of the clinical skills component if applicable), plus FLEX II;

(v) NBOME I, plus NBOME II, plus FLEX II;

(vi) the NBOME Part I or COMLEX Level I and NBOME Part II or COMLEX Level II and NBOME Part III or COMLEX Level III.

(I) An applicant must pass each part of an examination within three attempts, except that an applicant who has passed all but one part of an examination within three attempts may take the remaining part of the examination one additional time.

(J) Notwithstanding subparagraph (I) of this paragraph, an applicant is considered to have satisfied the requirements of this section if the applicant:

(i) passed all but one part of an examination approved by the board within three attempts and passed the remaining part of the examination within five attempts;

(ii) is specialty board certified by a specialty board that:

(I) is a member of the American Board of Medical Specialties; or

(II) is a member of the Bureau of Osteopathic Specialists; and

(iii) completed in this state an additional two years of postgraduate medical training approved by the board.

(K) An applicant who has not passed an examination for licensure in a ten-year period prior to the filing date of the application must:

(i) pass a monitored specialty certification examination or formal evaluation, a monitored recertification examination or formal evaluation, or a monitored examination of continued demonstration of qualifications by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists within the preceding ten years;

(ii) obtain through extraordinary circumstances, unique training equal to the training required for specialty certification as determined by a committee of the board and approved by the board, including but not limited to participation for at least six months in a training program approved by the board within twelve months prior to the application for licensure; or

(iii) pass the Special Purpose Examination (SPEX) within the preceding ten years.

(10) Good professional character--An applicant for licensure must not be in violation of or committed any act described in the Medical Practice Act, Tex. Occ. Code Ann. §§164.051-.053.

(11) One-year training program--a program that is one continuous year of postgraduate training approved by the board that is:

(A) accepted for certification by a specialty board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists; or

(B) accredited by one of the following:

(i) the Accreditation Council for Graduate Medical Education, or its predecessor;

(ii) the American Osteopathic Association;

(iii) the Committee on Accreditation of Preregistration Physician Training Programs, Federation of Provincial Medical Licensing Authorities of Canada;

(iv) the Royal College of Physicians and Surgeons of Canada; or

(v) the College of Family Physicians of Canada; or

(C) a postresidency program, usually called a fellowship, performed in the U.S. or Canada and approved by the board for additional training in a medical specialty or subspecialty.

(12) Sixty (60) semester hours of college courses--60 semester hours of college courses other than in medical school that are acceptable to The University of Texas at Austin for credit on a bachelor of arts degree or a bachelor of science degree; the entire primary, secondary, and premedical education required in the country of medical school graduation, if the medical school is located outside the United States or Canada; or substantially equivalent courses as determined by the board.

(13) Substantially equivalent to a Texas medical school--A medical school or college that is an institution of higher learning designed to select and educate medical students; provide students with the opportunity to acquire a sound basic medical education through training in basic sciences and clinical sciences; provide advancement of knowledge through research; develop programs of graduate medical education to produce practitioners, teachers, and researchers; and afford opportunity for postgraduate and continuing medical education. The school must provide resources, including faculty and facilities, sufficient to support a curriculum offered in an intellectual environment that enables the program to meet these standards. The faculty of the school shall actively contribute to the development and transmission of new knowledge. The medical school shall contribute to the advancement of knowledge and to the intellectual growth of its students and faculty through scholarly activity, including research. The medical school shall include, but not be limited to, the following characteristics:

(A) The facilities for basic sciences and clinical training (i.e., laboratories, hospitals, library, etc.) shall be adequate to ensure opportunity for proper education.

(B) The admissions standards shall be substantially equivalent to a Texas medical school.

(C) The basic sciences curriculum shall include the contemporary content of those expanded disciplines that have been traditionally titled gross anatomy, biochemistry, biology, histology, physiology, microbiology, immunology, pathology, pharmacology and neuroscience, as defined by the Texas Higher Education Coordinating Board.

(D) The fundamental clinical subjects, which shall be offered in the form of required patient-related clerkships, are internal medicine, obstetrics and gynecology, pediatrics, psychiatry, neurology, family practice, introduction to patient/physical examination, and surgery, as defined by the Texas Higher Education Coordinating Board.

(E) The curriculum shall be of at least 130 weeks in duration.

(F) The school shall provide advancement of knowledge through research.

(G) The school shall develop programs of graduate medical education to produce practitioners, teachers, and researchers.

(H) The school shall provide opportunity for postgraduate and continuing medical education.

(I) Medical education courses must be centrally organized, integrated and controlled into a continuous program which was conducted, monitored and approved by the medical school which issues the degree.

(14) Texas Medical Jurisprudence Examination (JP exam): the ethics examination developed [~~administered~~] by the board for licensure that must be passed by an applicant for licensure within three attempts with a score 75 or better.

(15) Three-year training program--three continuous years of postgraduate training in the United States or Canada, progressive in nature and acceptable for specialty board certification in one specialty area that is:

(A) accredited by one of the following:

(i) the Accreditation Council for Graduate Medical Education;

(ii) the American Osteopathic Association;

(iii) the Committee on Accreditation of Preregistration Physician Training Programs, Federation of Provincial Medical Licensing Authorities of Canada;

(iv) the Royal College of Physicians and Surgeons of Canada;

(v) the College of Family Physicians of Canada; or

(vi) all programs approved by the board after August 25, 1984; or

(B) a board-approved program for which a Faculty Temporary Permit was issued; or

(C) a postresidency program, usually called a fellowship, for additional training in a medical specialty or subspecialty, approved by the Texas State Board of Medical Examiners.

(b) The following words and terms, (concerning Telemedicine/Practice Across State Line/Practice of Medicine Definitions) when used in this chapter shall have the following meanings unless the context clearly indicates otherwise.

(1) Act that is part of patient care service--Any diagnosis, assessment, or treatment including the taking of diagnostic imaging studies as well as the preparation of pathological material for examination.

(2) Episodic consultation--Consultation on an irregular or infrequent basis involving no more than 24 patients of a physician's diagnostic or therapeutic practice per calendar year. Multiple consultations may be performed for one or more patients up to 24 patients per calendar year.

(3) Informal consultation--Consultation performed outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation of or exchange of direct or indirect compensation.

(4) Patient care service initiated in this state--Any act constituting the practice of medicine as defined in this chapter in which the patient is physically located in Texas at the time of diagnosis, treatment, or testing.

(5) Person--An individual unless otherwise expressly made applicable to a partnership, association, or corporation.

(6) Practice of medicine--A person shall be considered to be practicing medicine under any of the following circumstances listed in subparagraphs (A) - (D) of this paragraph. This definition does not negate the responsibility of applicants to demonstrate engagement in the active practice of medicine as set forth in section 163.11 of this title (relating to Active Practice of Medicine).

(A) the person publicly professes to be a physician or surgeon and diagnoses, treats, or offers to treat any mental or physical disease or disorder, or any physical deformity or injury by any system or method or to effect cures thereof;

(B) the person diagnoses, treats or offers to treat any mental or physical disease or disorder, or any physical deformity or injury by any system or method and to effect cures thereof and charges therefor, directly or indirectly, money or other compensation;

(C) the person exercises medical judgment, renders an opinion, or gives advice concerning the diagnosis or treatment of a patient, or makes any determination regarding the appropriate or necessary medical response to a particular patient's medical condition that affects the medical care of the patient; or

(D) the person is physically located in another jurisdiction, other than the state of Texas, and through any medium performs an act that is part of patient care service initiated in this state that would affect the diagnosis or treatment of the patient.

(7) State--Any state, territory, or insular possession of the United States and the District of Columbia.

§163.2. Licensure for United States/Canadian Medical School Graduates.

To be eligible for licensure, an applicant who is a graduate from a school in the United States or Canada must:

(1) - (6) (No change.)

(7) pass the Texas Medical Jurisprudence Examination with a score of 75 or better within three attempts.

§163.3. Licensure for Graduates of Acceptable Unapproved Medical Schools.

To be eligible for licensure, an applicant who is a graduate from a school outside the United States or Canada must:

(1) - (6) (No change.)

(7) pass the Texas Medical Jurisprudence Examination with a score of 75 or better within three attempts;

(8) - (11) (No change.)

§163.5. Licensure Documentation.

(a) (No change.)

(b) Documentation required of all applicants for licensure.

(1) - (9) (No change.)

(10) Medical License Verifications. Each applicant must have every state in which he or she has ever been licensed, regardless of the current status of the license, submit directly to this board a letter verifying the status of the license and a description of any sanctions or pending disciplinary matters; and [.]

(11) must demonstrate that any medical school education that was completed in the United States in satisfaction of their core basic and clinical science courses as established by the Texas Higher Education Coordinating Board and in satisfaction of the 130 weeks of required medical education was accredited by an accrediting body officially recognized by the United States Department of Education as the accrediting body for medical education leading to the doctor of medicine degree or the doctor of osteopathy degree. An applicant who is unable to comply with these requirements may in the alternative demonstrate that the applicant:

(A) received such medical education in a hospital or teaching institution sponsoring or participating in a program of graduate medical education accredited by the Accrediting Council for Graduate Medical Education, the American Osteopathic Association, or the Texas State Board of Medical Examiners in the same subject as the medical or osteopathic medical education if the hospital or teaching institution has an agreement with the applicant's school; or

(B) is specialty board certified by a board approved by the Bureau of Osteopathic Specialists or the American Board of Medical Specialties.

(c) (No change.)

(d) Applicants may be required to submit other documentation, which may include the following:

(1) - (2) (No change.)

(3) Malpractice. If an applicant has ever been named in a malpractice claim filed with any medical liability carrier or if an applicant has ever been named in a malpractice suit, the applicant must do the following:

(A) have each medical liability carrier complete a form furnished by the [~~this~~] board regarding each claim filed against the applicant's insurance;

(B) for each claim that becomes a malpractice suit, have the attorney representing the applicant in each suit submit a letter directly to the [~~this~~] board explaining the allegation, dates of the allegation, and current status of the suit. If the suit has been closed, the attorney must state the disposition of the suit, and if any money was paid, the amount of the settlement. The letter should include supporting court records. If such letter is not available, the Applicant will be required to furnish a notarized affidavit explaining why this letter cannot be provided; and

(C) (No change.)

(4) Inpatient Treatment for Alcohol/Substance Abuse or Mental Illness. Each applicant who [~~that~~] has been admitted to an inpatient facility within the last five years for the treatment of alcohol/substance abuse or mental illness shall submit documentation to include, but not limited to:

(A) - (D) (No change.)

(5) Outpatient Treatment for Alcohol/Substance Abuse or Mental Illness. Each applicant who [~~that~~] has been treated on an outpatient basis within the last five years for alcohol/substance abuse or mental illness shall submit documentation to include, but not limited to:

(A) - (C) (No change.)

(6) - (9) (No change.)

(e) (No change.)

§163.6. Examinations Accepted for Licensure.

(a) - (c) (No change.)

(d) An applicant who has not passed an examination listed in subsection (a) for licensure in a ten-year period prior to the filing date of the application must:

(1) - (3) (No change.)

(4) For those applicants who do not [~~no~~] pass all parts of all examinations required for licensure within a seven-year period, the board may consider for licensure graduates of simultaneous MD-PhD or DO-PhD programs who have passed all parts of their required examinations no later than two years after their MD or DO degree was awarded.

(e) JP Exam.

(1) In addition to the licensing examinations required for licensure under subsection (a) of this section, applicants must pass the JP exam with a score of 75 or better within three attempts.

[~~(2) The board shall provide for the administration of the JP exam.~~]

(2) [~~(3)~~] An examinee shall not be permitted to bring medical books, compends, notes, medical journals, calculators or other help into the examination room, nor be allowed to communicate by word or sign with another examinee while the examination is in progress without permission of the presiding examiner, nor be allowed to leave the examination room except when so permitted by the presiding examiner.

(3) [~~(4)~~] Irregularities during an examination such as giving or obtaining unauthorized information or aid as evidenced by observation or subsequent statistical analysis of answer sheets, shall be sufficient cause to terminate an applicant's participation in an examination, invalidate the applicant's examination results, or take other appropriate action.

(4) [~~(5)~~] An applicant who is unable to pass the JP exam within three attempts must appear before a committee of the board to address the applicant's inability to pass the examination and to re-evaluate the applicant's eligibility for licensure. It is at the discretion of the committee to allow an applicant additional attempts to take the JP exam.

[~~(6) Applicants for licensure who wish to request reasonable accommodations for the JP exam due to a disability must submit the request upon filing the Application.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405306
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 305-7016

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22 TAC §163.8, §163.9

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas State Board of Medical Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under the authority of the Occupations Code Annotated, §§151.002, 151.056, 155.001, 155.002, 155.003, 155.0031, 155.004, 155.005, 155.007, 155.008, 155.051, 155.0511, 155.052, 155.053, 155.054, 155.055, 155.056, 155.057, 155.058, and 155.104 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§163.8. Distinguished Professors Temporary License.

§163.9. State Health Agency Temporary License.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405307
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 305-7016

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CHAPTER 171. POSTGRADUATE TRAINING PERMITS

The Texas State Board of Medical Examiners proposes the repeal and replacement of §§171.1 - 171.7, concerning Purpose, Construction, Physician-in-Training Permits, Board-Approved Postgraduate Fellowship Training Programs, Institutional Permits, Duties of Program Directors to Report Certain Types of Conduct, and Inactive Status.

The repeal and new rules are necessary for reorganization and general cleanup of the chapter. Changes proposed establish criteria for the eligibility and discipline of physicians who apply for and hold postgraduate training permits and describes conduct that must be reported on all individuals who are in postgraduate training in order to protect public health and welfare. Changes proposed also modify the length of a physician in trailing permit from 18 months to the actual length of the training program.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners contemporaneously withdraws the proposed repeal of §§171.1 - 171.7 and proposed new §§171.1 - 171.12, which appeared in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6193). The Texas State Board of Medical Examiners also publishes the rule review of Chapter 171.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the repeal and new sections are in effect there will be no fiscal implications to state or local government as a result of enforcing the repeal and new sections as proposed. There may be an effect to Texas residency programs that will have to update administrative processes. There will be no effect to individuals required to comply with the repeal and new sections as proposed.

Ms. Shackelford also has determined that for each year of the first five years the repeal and new sections are in effect the public benefit anticipated as a result of enforcing the repeal and new sections will be updated rules. The intent of the changes is to provide greater efficiency in the issuance and regulation of postgraduate training permits. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018. A public hearing will be held at a later date.

22 TAC §§171.1 - 171.7

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas State Board of Medical Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under the authority of the Occupations Code Annotated, §§153.001, 155.001, 155.002, 155.104, and 155.105 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§171.1. Construction.

§171.2. Postgraduate Resident Permits.

§171.3. Institutional Permits.

§171.4. Visiting Professor Permit.

§171.5. National Health Service Corps Permit.

§171.6. Faculty Temporary Permit.

§171.7. Postgraduate Research Permit.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405310
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 305-7016

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22 TAC §§171.1 - 171.7

The new sections are proposed under the authority of the Occupations Code Annotated, §153.001, 155.001, 155.002, 155.104, and 155.105 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§171.1. Purpose.

Pursuant to the Board's authority under Tex. Occ. Code §155.105 of the Medical Practice Act, this chapter is promulgated to:

(1) Provide criteria for the eligibility and discipline of physicians who apply for and are granted physician-in-training permits; and

(2) Set forth conduct that must be reported on all individuals who are in postgraduate training in order to protect public health and welfare.

§171.2. Construction.

(a) Unless otherwise indicated, permit holders under this chapter shall be subject to the duties, limitations, disciplinary actions, rehabilitation order provisions, and procedures applicable to licensees

in the Medical Practice Act and board rules. Permit holders under this chapter shall also be subject to the limitations and restrictions elaborated in this chapter.

(b) Permit holders under this chapter shall cooperate with the board and board staff involved in investigation, review, or monitoring associated with the permit holder's practice of medicine. Such cooperation shall include, but not be limited to, permit holder's written response to the board or board staff written inquiry within 14 days of receipt of such inquiry.

(c) In accordance with §155.105 of the Medical Practice Act, the board shall retain jurisdiction to discipline a permit holder whose permit has been terminated, canceled, and/or expired if the permit holder violated the Medical Practice Act or board rules during the time the permit was valid.

(d) The issuance of a permit to a physician shall not be construed to obligate the board to issue the physician subsequent permits or licenses. The board reserves the right to investigate, deny a permit or full licensure, and/or discipline a physician regardless of when the information was received by the board.

§171.3. Physician-in-Training Permits.

(a) Definitions.

(1) Approved Postgraduate Training Program: a clearly defined and delineated postgraduate medical education training program, including postgraduate subspecialty training programs, approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the Committee on Accreditation of Preregistration Physician Training Programs, the Federation of Provincial Medical Licensing Authorities of Canada (internships prior 1994), the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

(2) Board-approved Postgraduate Fellowship Training Program: a clearly defined and delineated postgraduate subspecialty-training program approved by the Texas State Board of Medical Examiners.

(3) Postgraduate Resident: a physician who is in postgraduate training as an intern, resident, or fellow in an approved postgraduate training program or a board-approved postgraduate fellowship training program.

(4) Physician-in-Training Permit:

(A) A physician-in-training permit is a permit issued by the board in its discretion to a physician who does not hold a license to practice medicine in Texas and is enrolled in a training program as defined in paragraphs (1) and (2) of this subsection in Texas, regardless of his/her postgraduate year (PGY) status within the program.

(B) The permit shall be effective for the length of the postgraduate training program as reported by the training program.

(C) A physician-in-training permit is valid only for the practice of medicine within the training program for which it was approved. If a permit holder enters into a new program that is not covered by the issued permit, the permit shall be terminated and the permit holder must apply for a new permit for the new program.

(D) A physician-in-training permit holder is restricted to the supervised practice of medicine that is part of and approved by the training program. The permit does not allow for the practice of medicine that is outside of the approved program.

(b) Qualifications of Physician-in-Training Permit Holders.

(1) To be eligible for a physician-in-training permit, an applicant must present satisfactory proof to the board that the applicant:

(A) is at least 18 years of age;

(B) is of good professional character and has not violated §§164.051 - 164.053 of the Medical Practice Act;

(C) is a graduate of a medical school;

(D) has been accepted into an approved postgraduate training program or board-approved postgraduate fellowship training program; and

(E) has been credentialed by the postgraduate training program to include verification by the program of:

(i) the applicant's identity; and

(ii) the applicant's character and academic qualifications including verification of medical school graduation.

(2) To be eligible for a physician-in-training permit, an applicant must not have:

(A) a medical license, permit, or other authority to practice medicine that is currently restricted for cause, cancelled for cause, suspended for cause, revoked or subject to another form of discipline in a state or territory of the United States, a province of Canada, or a uniformed service of the United States;

(B) an investigation or proceeding pending against the applicant for the restriction, cancellation, suspension, revocation, or other discipline of the applicant's medical license, permit, or authority to practice medicine in a state or territory of the United States, a province of Canada, or a uniformed service of the United States;

(C) a prosecution pending against the applicant in any state, federal, or Canadian court for any offense that under the laws of this state is a felony, a misdemeanor that involves the practice of medicine, or a misdemeanor that involves a crime of moral turpitude.

(c) Application for Physician-in-Training Permit.

(1) Application Procedures.

(A) Applications for a physician-in-training permit shall be submitted to the board no earlier than the sixtieth (60th) day prior to the date the applicant intends to begin postgraduate training in Texas to ensure the application information is not outdated. To assist in the expedited processing of the application, the application should be submitted as early as possible within the sixty-day window prior to the date the applicant intends to begin postgraduate training in Texas.

(B) The board may, in unusual circumstances, allow substitute documents where exhaustive efforts on the applicant's part to secure the required documents is presented. These exceptions shall be reviewed by the board's executive director on a case-by-case basis.

(C) For each document presented to the board which is in a foreign language, an official word-for-word translation must be furnished. The board's definition of an official translation is one prepared by a government official, official translation agency, or a college or university official, on official letterhead. The translator must certify that it is a "true translation to the best of his/her knowledge, that he/she is fluent in the language, and is qualified to translate." He/she must sign the translation with his/her signature notarized by a Notary Public. The translator's name and title must be typed/printed under the signature.

(D) The board's executive director shall review each application for training permit and shall approve the issuance of physician-in-training permits for all applicants eligible to receive a permit.

The executive director shall also report to the board the names of all applicants determined to be ineligible to receive a permit, together with the reasons for each recommendation. The executive director may refer any application to a committee or panel of the board for review of the application for a determination of eligibility.

(E) An applicant deemed ineligible to receive a permit by the executive director may request review of such recommendation by a committee or panel of the board within 20 days of written receipt of such notice from the executive director.

(F) If the committee or panel finds the applicant ineligible to receive a permit, such recommendation together with the reasons for the recommendation, shall be submitted to the board unless the applicant makes a written request for a hearing within 20 days of receipt of notice of the committee's or panel's determination. The hearing shall be before an administrative law judge of the State Office of Administrative Hearings and shall comply with the Administrative Procedure Act, the rules of the State Office of Administrative Hearings and the board. The board shall, after receiving the administrative law judge's proposed findings of fact and conclusions of law, determine the eligibility of the applicant to receive a permit. A physician whose application to receive a permit is denied by the board shall receive a written statement containing the reasons for the board's action.

(G) All reports and investigative information received or gathered by the board on each applicant are confidential and are not subject to disclosure under the Public Information Act, Gov't Code Chapter 552 and the Medical Practice Act, Tex. Occ. Code §§155.007(g), 155.058, and 164.007(c). The board may disclose such reports and investigative information to appropriate licensing authorities in other states.

(2) Physician-in-Training Permit Application. An application for a physician-in-training permit must be on forms furnished by the board and include the following:

(A) the required fee as mandated in the Medical Practice Act, §153.051 and as construed in board rules, payable by personal check, money order or cashier's check through a United States bank;

(B) certification by the director of medical education, and program director or supervising physician, if the director of medical education is not a physician, of the postgraduate training program on a form provided by the board that certifies that:

(i) the program meets the definition of an approved postgraduate training program in subsection (a)(2) and (3) of this section;

(ii) the applicant has met all educational and character requirements established by the program and has been accepted into the program;

(iii) the director has received a letter from the dean of the applicant's medical school which states that the applicant is scheduled to graduate from medical school before the date the applicant plans to begin postgraduate training; and

(iv) if the applicant is completing rotations in Texas as part of the applicant's residency out-of-state training program or with the military, the facility at which the rotations are being completed, and the dates the rotations will be completed in Texas;

(C) arrest records. If an applicant has ever been arrested, a copy of the arrest and arrest disposition must be requested from the arresting authority by the applicant and said authority must submit copies directly to the board;

(D) medical records for inpatient treatment for alcohol/substance abuse, mental illness, and physical illness. Each applicant who has been admitted to an inpatient facility within the last five years for the treatment of alcohol/substance abuse, mental illness, or physical illness shall submit documentation to include, but not limited to:

(i) an applicant's statement explaining the circumstances of the hospitalization;

(ii) all records, submitted directly from the inpatient facility;

(iii) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(iv) a copy of any contracts signed with any licensing authority or medical society or impaired physician's committee;

(E) medical records for outpatient treatment for alcohol/substance abuse, mental illness, or physical illness. Each applicant that has been treated on an outpatient basis within the last five years for alcohol/substance abuse, mental illness shall submit documentation to include, but not limited to:

(i) an applicant's statement explaining the circumstances of the outpatient treatment;

(ii) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(iii) a copy of any contracts signed with any licensing authority or medical society or impaired physician's committee;

(F) an oath on a form provided by the board attesting to the truthfulness of statements provided by the applicant;

(G) such other information or documentation the board and/or the executive director deem necessary to ensure compliance with this chapter, the Medical Practice Act and board rules.

(d) Expiration of Physician-in-Training Permit.

(1) Physician-in-Training permits shall be issued with effective dates corresponding with the beginning and ending dates of the postgraduate resident's training program as reported to the board by the program director.

(2) Physician-in-training permits shall expire on any of the following, whichever occurs first:

(A) on the reported ending date of the postgraduate training program;

(B) on the date a postgraduate training program terminates or otherwise releases a permit holder from its training program; or

(C) on the date the permit holder obtains full licensure or temporary licensure pending full licensure pursuant to §155.002 of the Act.

(3) Physician-in-training permit holders who are issued permits on or after April 1, 2005, and who require extensions to remain in a training program after a program's reported ending date must submit a written request to the board and fee, if required, along with a statement by the program director authorizing the request for the extension. Such extensions shall be granted at the discretion of the board's executive director and may not be for longer than 90 days unless good cause is shown.

(4) If a postgraduate resident was issued a permit for a program with an initial start date prior to April 1, 2005 and the permit is set to expire before the ending date of the permit holder's training program, and the expiration date is on or after July 2, 2005, the program director and/or permit holder must submit an application and fee requesting that the permit be extended to the ending date of the training program. The fee shall be in accordance with §175.1(2)(B) of this title (relating to Fees, Penalties, and Applications).

(e) Annual reports. Program directors for postgraduate training programs must ensure that the board receives certain information annually in order to keep the board informed on a permit holder's progress while in the approved training program. The required information shall be sent to the board on forms provided by the board and shall include:

(1) information regarding the permit holder's criminal and disciplinary history, professional character, mailing address, and place where engaged in training since the program director's last report;

(2) certification by the permit holder's program director, on a form provided by the board, regarding the permit holder's training; and

(3) such other information or documentation the board and/or the executive director deem necessary to ensure compliance with this chapter, the Medical Practice Act and board rules.

§171.4. Board-Approved Postgraduate Fellowship Training Programs.

(a) The executive director may in his/her discretion, upon written request, approve training programs as referenced in §171.3(a)(3) of this chapter for up to three years. The initial request should be submitted to the executive director 180 days prior to the beginning date of the program to assist in the expedited processing of an application. Said training programs shall be limited to postgraduate subspecialty programs. If the executive director does not recommend approval, the program's director may appeal to the board for its discretionary consideration of the request.

(b) Approval of training programs shall include but not be limited to the following considerations:

(1) the goals and objectives of the program;

(2) the process by which the program selects subspecialty postgraduate residents;

(3) whether prior residency training in a related specialty is required of subspecialty postgraduate residents in the program;

(4) the duties and responsibilities required of subspecialty postgraduate residents in the program including the number of subspecialty postgraduate residents to be enrolled each year and when subspecialty postgraduate residents are required to be permanently licensed;

(5) the formal educational experiences required of subspecialty postgraduate residents in the program, including grand rounds, seminars and journal club;

(6) the scholarly research required of subspecialty postgraduate residents in the program, including participation in peer reviewed and funded research which may result in publications or presentations at regional and national scientific meetings;

(7) the type of supervision provided for subspecialty postgraduate residents by the program;

(8) the curriculum vitae, including academic appointments, of all supervising staff;

(9) the academic affiliation of the program;

(10) the methods for evaluation of subspecialty postgraduate residents by the program; and

(11) whether a specialty board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists gives credit for the program; and

(12) the progressive nature of the fellowship if the fellowship training program is over one year in length.

(c) All program directors for fellowship training programs that have been approved by the board must apply to be re-evaluated to assure compliance with the above considerations and consideration of continuation of the fellowship training program. The program director must apply for re-evaluation at least six months prior to the expiration of the approved program in order to prevent a lapse in time of the fellowship training program. Permit holders shall be allowed to complete their training program regardless of continuing program re-evaluation.

(d) All board-approved fellowships that subsequently become approved by the ACGME or AOA must notify the board within 30 days of their approval. Fellowships may not be dually approved by the board and ACGME or AOA. A board-approved fellowship that becomes ACGME or AOA approved immediately loses its board-approved status when its new approval becomes effective through the ACGME or AOA.

(e) The executive director of the board may, in his/her discretion, issue a temporary physician-in-in-training permit to an applicant if the applicant and the postgraduate training program have submitted written requests. The executive director, in his/her discretion, will determine the length of the permit and may issue additional temporary physician-in-training training permits to an applicant.

§171.5. Institutional Permits.

All physicians who are in postgraduate training must have a physician-in-training permit or full licensure. The board will amend all institutional permits to physician-in-training permits for the remaining period of the program under which an institutional permit holder is currently training. This shall not preclude an institutional permit holder from applying for full licensure while in a postgraduate training program.

§171.6. Duties of Program Directors to Report Certain Types of Conduct.

(a) Failure of any postgraduate training program director to comply with the provisions of this chapter or the Medical Practice Act §160.002 and §160.003 may be grounds for disciplinary action against the program director.

(b) The director of each approved postgraduate training program shall report in writing to the executive director of the board the following circumstances within seven days of the director's knowledge for any physician-in-training permit holder completing postgraduate training:

(1) if a physician did not begin the training program due to failure to graduate from medical school as scheduled or for any other reason(s);

(2) if a physician has been or will be absent from the program for more than 21 consecutive days (excluding vacation, family, or military leave) and the reason(s) why;

(3) if a physician has been arrested after the permit holder begins training in the program;

(4) if a physician poses a continuing threat to the public welfare as defined under Tex. Occ. Code §151.002(a)(2), as amended;

(5) if the program has taken action that adversely affects the physician's status or privileges in a program for a period longer than 30 days;

(6) if the program has suspended the physician from the program;

(7) if the program has requested termination or terminated the physician from the program, requested or accepted withdrawal of the physician from the program, or requested or accepted resignation of the permit holder from the program; and/or

(8) any such similar action and the reason(s) why.

(c) A violation of §§164.051 - 164.053 or any other provision of the Medical Practice Act is grounds for disciplinary action by the Board.

§171.7. Inactive Status.

(a) A physician-in-training permit holder who is placed on suspension, dismissed, or terminated by a training program shall have his permit placed on inactive status.

(b) The board retains jurisdiction to investigate any physician-in-training permit holder placed on inactive status for possible violation(s) of the Medical Practice Act and/or board rules.

(c) If a postgraduate training program lifts the suspension of a physician-in-training permit holder, the program must notify the board of the lifted suspension and board shall return the physician's permit to active status effective the date the board is notified that the suspension is lifted.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405311
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 305-7016

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CHAPTER 172. TEMPORARY LICENSES

22 TAC §§172.1 - 172.9

The Texas State Board of Medical Examiners proposes new §§172.1-172.9, concerning Temporary Licenses. This creates a new chapter that authorizes the Board to adopt rules relating to granting certain temporary licenses.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the rules are in effect there will be no fiscal implications to state or local government as a result of enforcing the rules as proposed. There will be no effect to individuals required to comply with the sections as proposed.

Ms. Shackelford also has determined that for each year of the first five years the rules as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be to provide criteria for the eligibility and discipline of physicians who apply for and are granted temporary licenses. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The new rules are proposed under the authority of the Occupations Code Annotated, §155.104 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§172.1. Purpose.
Pursuant to Tex. Occ. Code Section 155.104 of the Medical Practice Act that authorizes the Board to adopt rules relating to granting temporary licenses, this chapter is promulgated to provide criteria for the eligibility and discipline of physicians who apply for and are granted temporary licenses.

§172.2. Construction.

(a) Unless otherwise indicated, temporary license holders under this chapter shall be subject to the duties, limitations, disciplinary actions, rehabilitation order provisions, and procedures applicable to licensees in the Medical Practice Act and board rules. Temporary license holders under this chapter shall also be subject to the limitations and restrictions elaborated in this chapter.

(b) Temporary license holders under this chapter shall cooperate with the board and board staff involved in investigation, review, or monitoring associated with the temporary license holder's practice of medicine. Such cooperation shall include, but not be limited to, temporary license holder's written response to the board or board staff written inquiry within 14 days of receipt of such inquiry.

(c) In accordance with §155.105 of the Medical Practice Act, the board shall retain jurisdiction to discipline a temporary license holder whose permit has been terminated, canceled, and/or expired if the temporary license holder violated the Medical Practice Act or board rules during the time the temporary license was valid.

(d) The issuance of a temporary license to a physician shall not be construed to obligate the board to issue the physician subsequent permits or licenses. The board reserves the right to investigate, deny a permit, temporary license, or full licensure, and/or discipline a physician regardless of when the information was received by the board.

(e) Nothing in this chapter shall be construed to prevent the Board from issuing temporary licenses to those physicians awaiting full licensure pursuant to Section 163.7 of this title (relating to Temporary Licensure - Regular) or to those licenses who qualify for CME temporary licenses pursuant to Section 166.2(k) of this title (relating to CME temporary licenses) .

§172.3. Distinguished Professors Temporary License.

(a) The executive director of the board may issue a distinguished professors temporary license to an applicant:

(1) who has passed the Texas medical jurisprudence examination;

(2) whose application has been filed, processed, and found to be in order. The application shall be complete in every detail except that the applicant will not be required to have taken and passed the SPEX examination as set forth in §163.4 of this title (relating to Procedural Rules for Licensure Applicants);

(3) who holds an appointment as a salaried full professor on the faculty working full-time in one of the following institutions:

(A) University of Texas Medical Branch at Galveston;

(B) University of Texas Southwestern Medical Center at Dallas;

(C) University of Texas Health Science Center at Houston;

(D) University of Texas Health Science Center at San Antonio;

(E) University of Texas Health Center at Tyler;

(F) University of Texas M.D. Anderson Cancer Center;

(G) Texas A&M University College of Medicine;

(H) Texas Tech University School of Medicine;

(I) Baylor College of Medicine; or

(J) University of North Texas Health Science Center at Fort Worth.

(b) The distinguished professors temporary license shall be requested by the president, dean or chief academic officer of the institution as defined in subsection (a)(3) of this section and shall be valid only in the institution or its affiliated hospitals.

(c) The distinguished professors temporary license shall be valid for a continuous one-year period; however, the permit is revocable at any time the board deems necessary. The distinguished professors temporary license shall automatically expire one year after the date of issuance. The distinguished professors temporary license is renewable one time, at the discretion of the executive director.

(d) At the conclusion of this one-year period, the distinguished professor shall present recommendations from the president, dean or chief academic officer of the institution, and shall petition the board for a permanent, unrestricted license to practice medicine in Texas. If this petition is denied, the institution may request a one-year extension of the distinguished professors temporary license. If an extension is granted, and following termination of such extension, the distinguished professor shall again present recommendations from the president, dean or chief academic officer of the institution and re-petition the board for a permanent, unrestricted license to practice medicine in Texas. If the petition is again denied, no further distinguished professors temporary license shall be issued.

(e) If the board grants the petition for licensure, the distinguished professor may be issued a permanent, unrestricted license.

§172.4. State Health Agency Temporary License.

An applicant may elect to apply for a state health agency temporary license in lieu of licensure.

(1) The executive director of the board may issue such a temporary license to an applicant:

(A) who holds a valid license in another state or Canadian province on the basis of an examination, that is accepted by the board for licensure;

(B) who has passed the Texas medical jurisprudence examination;

(C) whose application has been filed, processed, and found to be in order. The application shall be complete in every detail with the exception of compliance with §163.1(a)(9)(K) of this title (relating to Definitions of Examinations accepted by the board for licensure); and

(D) who holds a salaried, administrative, or clinical position with an agency of the State of Texas.

(2) The state health agency temporary license shall be requested by the chief administrative officer of the employing state agency and shall be issued exclusively to that agency. The chief administrative officer shall state whether the temporary license is for a:

(A) clinical position. This temporary license will be valid for a one-year period from the date of issuance and will not be renewable. The temporary license is revocable at any time the board deems necessary. To practice beyond one year, the holder of the temporary license must fully comply with §163.1(a)(9)(K) of this title (relating to Definitions of Examinations accepted by the board for licensure). During the period that the state health agency clinical temporary license is in effect, the physician will be supervised by a licensed staff physician who will regularly review the temporary license holder's skill and performance. This temporary license will be marked "clinical"; or

(B) administrative non-clinical position. This temporary license will be valid for a one-year period from the date of issuance; however, it is revocable at any time the board deems necessary. The temporary license shall automatically expire one year after the date of issuance but may be re-issued annually at the request of the chief administrative officer of the employing state agency and at the discretion of the Texas State Board of Medical Examiners. The holder of a state health agency temporary license, not designated as clinical, shall not practice medicine as that term is defined in the Medical Practice Act, TEX. OCCUPATIONS CODE ANN. §151.002 (a)(13). This temporary license will be marked "administrative."

§172.5. Visiting Physician Temporary License.

(a) The executive director of the board may issue a permit to practice medicine to an applicant who intends to practice under the supervision of licensed Texas physician for educational purposes or in order to practice charity care to underserved populations in Texas. In order to be determined eligible for a visiting physician permit the applicant must:

(1) hold a current medical license that is free of any restriction, disciplinary order or probation in another state, territory, or Canadian province;

(2) not have any medical license that is under restriction, disciplinary order, or probation in another state, territory, or Canadian province;

(3) be supervised by a physician with an unrestricted license in Texas;

(4) present written verification from the physician who will be supervising the applicant that the physician will provide continuous supervision of the applicant. Constant physical presence of the physician is not required but the physician but remain readily available; and

(5) present written verification from the supervising physician as to the purpose for the requested permit.

(b) Visiting physician permits shall be valid for no more than ten working days and for a specified locale and purpose. The executive director of the board, in his/her discretion, may extend the length of the state if the applicant shows good cause for why the extended time is need.

§172.6. Visiting Professor Temporary License.

The board may issue a temporary license to practice medicine to a physician appointed as a visiting professor by a Texas medical school in accordance with this section.

(1) The visiting professor temporary license may be valid for any number of 31-day increments not to exceed 24 increments.

The incremental periods wherein the temporary license is valid need not be contiguous, but rather may be in any arrangement approved by the executive director of the board.

(2) The visiting professor temporary license shall state on its face the periods during which it will be valid. If all periods of validity are not known at the time of the temporary license issuance, the temporary license holder shall request that the executive director of the board endorse the temporary license with each incremental period of validity as such becomes known. No temporary license shall be valid at any time when the period of validity is not stated on the temporary license unless suitable temporary alternative arrangements have been presented to and accepted by the executive director or secretary-treasurer of the board.

(3) The visiting professor temporary license shall be issued to the institution authorizing the named visiting professor to practice medicine within the teaching confines of the applying medical school as a part of duties and responsibilities assigned by the school to the visiting professor. The visiting professor may participate in the full activities of the department in whichever hospital the appointee's department has full responsibility for clinical, patient care, and teaching activities.

(4) The visiting professor and the school shall file affidavits with the board affirming acceptance of the terms, limitations and conditions imposed by the board on the medical activities of the visiting professor.

(5) The application for visiting professor temporary license or the renewal thereof shall be presented to the secretary-treasurer or executive director of the board at least 30 days prior to the effective date of the appointment of the visiting professor. The application shall be made by the chairman of the department in which the visiting professor will teach and provide such information and documentation to the board as may be requested. Such application shall be endorsed by the dean of the medical school or by the president of the institution.

(6) All applications shall state the date when the visiting professor shall begin performance of duties.

§172.7. National Health Service Corps Temporary License.

The board may issue a temporary license to practice medicine to a physician who has contracted with the National Health Service Corps to practice medicine in Texas under the following terms and conditions.

(1) The physician must be a graduate of a medical school approved by the board. An 8 1/2 x 11 notarized true copy of the original medical diploma shall be submitted to the board.

(2) The physician must hold a valid, unrestricted license in another state or territory to practice medicine. A notarized true copy of the license registration certificate shall be submitted to the board. If the physician is not licensed in another state, he or she must have passed either the United States Medical Licensing Examination (USMLE), within three attempts, with a score of 75 or better on each step, all steps must be passed within seven years, or the National Board of Osteopathic Medical Examiners Examination (NBOME) or its successor, within three attempts, all steps must be passed within seven years, or the National Board of Medical Examiners Examination (NBME) within three attempts, all steps must be passed within seven years. A certified transcript of the scores shall be submitted to the board by the appropriate authority.

(3) The physician must have a valid contract with the National Health Service Corps. The temporary license will expire at the termination of the contract with the National Health Service Corps. A notarized true copy of the contract shall be submitted to the board.

(4) The temporary license shall be issued for one year and may be renewed.

(5) The temporary license allows the physician to practice medicine only within the scope of his or her contract with the National Health Service Corps.

§172.8. Faculty Temporary License.

(a) The board may issue a faculty temporary license to practice medicine to a physician appointed by a Texas medical school in accordance with this section:

(1) The physician must hold a current medical license that is free of any restriction, disciplinary order or probation in another state, territory, or Canadian province; or have completed three years of postgraduate residency training.

(2) Each medical license held in another state, territory, or Canadian province must be free of any restrictions, disciplinary order or probation.

(3) The physician must not have failed a licensure examination that would prevent the physician from obtaining an unrestricted physician license in Texas.

(4) The physician must hold a salaried faculty position of assistant professor-level or higher working full-time in one of the following institutions:

(A) University of Texas Medical Branch at Galveston;

(B) University of Texas Southwestern Medical Center at Dallas;

(C) University of Texas Health Science Center at Houston;

(D) University of Texas Health Science Center at San Antonio;

(E) University of Texas Health Center at Tyler;

(F) University of Texas M.D. Anderson Cancer Center;

(G) Texas A&M University College of Medicine;

(H) Texas Tech University School of Medicine;

(I) Baylor College of Medicine; or

(J) University of North Texas Health Science Center at Fort Worth.

(5) Notwithstanding paragraph (4) of this subsection, a physician is eligible for a faculty temporary license permit if the physician holds a faculty position of assistant professor-level or higher and works at least part-time in one of the institutions named in paragraph (1) of this subsection and;

(A) the physician is on active duty in the United States military; and,

(B) the physician's practice under the faculty temporary license will fulfill a critical need of the citizens of Texas.

(6) The physician must sign an oath on a form provided by the board swearing that the applicant has read and is familiar with board rules and the Medical Practice Act; will abide by board rules and the Medical Practice Act in activities permitted by this chapter; and will subject themselves to the disciplinary procedures of the Texas State Board of Medical Examiners.

(b) The faculty temporary license shall be issued for a period of one year, and may, in the discretion of the executive director of the board, be renewed three times.

(c) The faculty temporary license holder's practice of medicine shall be limited to the teaching confines of the applying medical school as a part of duties and responsibilities assigned by the school to the physician.

(d) The physician may participate in the full activities of the department in whichever hospitals the appointee's department has full responsibility for clinical, patient care, and teaching activities.

(e) The physician and the school shall file affidavits with the board affirming acceptance of the terms, limitations, and conditions imposed by the board on the medical activities of the physician.

(f) The application and fee for the faculty temporary license or the renewal thereof shall be presented to the executive director of the board at least 30 days prior to the effective date of the appointment of the physician.

(g) The application shall be made by the chairman of the department in which the physician will teach and provide such information and documentation to the board as may be requested.

(h) The application shall be endorsed by the dean of the medical school or by the president of the institution.

(i) Three years in a teaching faculty position at any institution listed in subsection (a)(4) of this section may be equivalent to three years of approved postgraduate training if, at the conclusion of this three-year period, the physician presents recommendations in his or her behalf from the chief administrative officer and the president of the institution.

§172.9. Postgraduate Research Temporary License.

The board may issue a temporary license to practice medicine to a medical school graduate, who holds a research appointment at a Texas medical school, in a program approved by the board, under the following terms and conditions listed in paragraphs (1)-(6) of this section.

(1) The research must be in clinical medicine and/or the basic sciences of medicine.

(2) The research must be conducted in the Texas medical school or its affiliated institutions.

(3) The research appointment must be approved by the Dean of the medical school or the president of the institution.

(4) The research appointment must be supervised by a faculty member of the Texas medical school who has an active unrestricted Texas medical license.

(5) The research appointment must be of good professional character as elaborated in the Medical Practice Act.

(6) The Postgraduate Research Temporary License may be issued for a maximum of one year and is not renewable.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405312
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 305-7016

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CHAPTER 182. USE OF EXPERTS

22 TAC §182.5

The Texas State Board of Medical Examiners proposes an amendment to §182.5, concerning Use of Expert Panel. The amendment clarifies the selection criteria for appointment to the expert panel.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the rule is in effect there will be no fiscal implications to state or local government as a result of enforcing the rule as proposed. There will be no effect to individuals required to comply with the section as proposed.

Ms. Shackelford also has determined that for each year of the first five years the rule as proposed is in effect the public benefit anticipated as a result of enforcing the section will be clarification to requirements for serving on the expert panel. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The amendment is proposed under the authority of the Occupations Code Annotated, §154.058 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§182.5. Use of Expert Panel.

If the initial review of a complaint indicates that an act by a licensee may fall below an acceptable standard of care, the complaint shall be referred to the expert physician panel for review.

(1) Composition and qualifications. Selection criteria for appointment to the panel shall include:

(A) licensed to practice medicine in Texas

(B) certification by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists;

(C) no history of licensure restriction;

(D) no history of peer discipline; [~~and~~]

(E) acceptable malpractice complaint history; and [~~.~~]

(F) in active practice as defined by §163.11 of this title (relating to the Active Practice of Medicine).

(2) Duties of the expert panel. Expert panel members will assist the board with complaints and investigations relating to medical competency. Cases concerning possible violation of the standard of care will be referred to the expert panel. Panel members who practice in the same specialty or similar area of practice as the licensee will be assigned to participate in the review of cases as deemed appropriate. Panel members assigned to a case will review all the medical information and records collected by the board and shall report findings in the prescribed format. A report shall be prepared by the expert panel to include the following:

(A) findings involving medical competency;

(B) applicable standard of care; and

(C) the clinical basis for the determinations, including any reliance on peer-reviewed journals, studies, or reports.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 305-7016

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CHAPTER 183. ACUPUNCTURE

22 TAC §183.4

The Texas State Board of Medical Examiners proposes an amendment to §183.4, concerning Acupuncture. The amendment is necessary because the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) examination has been reformatted and these changes recognize that reformatting.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the rule is in effect there will be no fiscal implications to state or local government as a result of enforcing the rule as proposed. There will be no effect to individuals required to comply with the section as proposed.

Ms. Shackelford also has determined that for each year of the first five years the rule as proposed is in effect the public benefit anticipated as a result of enforcing the section will be compliance with NCCAOM reformatting. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The amendment is proposed under the authority of the Occupations Code Annotated, §205.203 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§183.4. Licensure.

(a) Qualifications. An applicant must present satisfactory proof to the acupuncture board that the applicant:

(1) is at least 21 years of age;

(2) is of good professional character as defined in (183.2 of this title (relating to Definitions);

(3) has successfully completed 60 semester hours of general academic college level courses, other than in acupuncture school, that are not remedial and would be acceptable at the time they were completed for credit on an academic degree at a two or four year institution of higher education within the United States accredited by an agency recognized by the Higher Education Coordinating Board or its equivalent in other states as a regional accrediting body. Coursework completed as a part of a degree program in acupuncture or Oriental medicine may be accepted by the acupuncture board if, in the opinion of the acupuncture board, such coursework is substantially equivalent to the required hours of general academic college level coursework;

(4) is a graduate of an acceptable approved acupuncture school or received and completed training which, in the opinion of the acupuncture board, was substantially equivalent to training provided by such a school;

(5) has taken and passed, within three attempts, each component of the full National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) examination.If an applicant submits to multiple attempts on a component before and on or after June 1, 2004, the number of attempts shall be combined based on the subject matter tested;

(6) has taken and passed the CCAOM (Council of Colleges of Acupuncture and Oriental Medicine) Clean Needle Technique (CNT) course and practical examination; and

(7) is able to communicate in English as demonstrated by one of the following:

(A) passage of the NCCAOM examination taken in English;

(B) passage of the TOEFL (Test of English as a Foreign Language) with a score of 550 or higher on the paper based test or with a score of 213 or higher on the computer based test;

(C) passage of the TSE (Test of Spoken English) with a score of 45 or higher;

(D) passage of the TOEIC (Test of English for International Communication) with a score of 500 or higher; or

(E) at the discretion of the acupuncture board, passage of any other similar, validated exam testing English competency given by a testing service with results reported directly to the acupuncture board or with results otherwise subject to verification by direct contact between the testing service and the acupuncture board.

(b) Procedural rules for licensure applicants. The following provisions shall apply to all licensure applicants.

(1) Applicants for licensure:

(A) whose documentation indicates any name other than the name under which the applicant has applied must furnish proof of the name change;

(B) whose application for licensure which has been filed with the board office and which is in excess of two years old from the date of receipt shall be considered inactive. Any fee previously submitted with that application shall be forfeited. Any further application procedure for licensure will require submission of a new application and inclusion of the current licensure fee.

~~[(C) will be allowed to sit for each component of the NCCAOM examination only three times;]~~

(C) [~~(D)~~] who in any way falsify the application may be required to appear before the acupuncture board. It will be at the discretion of the acupuncture board whether or not the applicant will be issued a Texas acupuncture license;

(D) [~~(E)~~] on whom adverse information is received by the acupuncture board may be required to appear before the acupuncture board. It will be at the discretion of the acupuncture board whether or not the applicant will be issued a Texas license;

(E) [~~(F)~~] shall be required to comply with the acupuncture board's rules and regulations which are in effect at the time the completed application form and fee are filed with the board;

(F) [~~(G)~~] may be required to sit for additional oral, written, or practical examinations or demonstrations that, in the opinion of the acupuncture board, are necessary to determine competency of the applicant;

(G) [~~(H)~~] must have the application for licensure completed and legible in every detail 60 days prior to the acupuncture board meeting in which they are to be considered for licensure unless otherwise determined by the acupuncture board based on good cause.

(2) Applicants for licensure who wish to request reasonable accommodation due to a disability must submit the request at the time of filing the application.

(3) Applicants who have been licensed in any other state, province, or country shall complete a notarized oath or other verified sworn statement in regard to the following:

(A) whether the license, certificate, or authority has been the subject of proceedings against the applicant for the restriction for cause, cancellation for cause, suspension for cause, or revocation of the license, certificate, or authority to practice in the state, province, or country, and if so, the status of such proceedings and any resulting action; and,

(B) whether an investigation in regard to the applicant is pending in any jurisdiction or a prosecution is pending against the applicant in any state, federal, national, local, or provincial court for any offense that under the laws of the state of Texas is a felony, and if so, the status of such prosecution or investigation.

(4) An applicant for a license to practice acupuncture may not be required to appear before the acupuncture board or any of its committees unless the application raises questions about the applicant's:

(A) physical or mental impairment;

(B) criminal conviction; or

(C) revocation of a professional license.

(c) Licensure documentation.

(1) Original documents/interview. An applicant must appear for a personal interview at the board offices and present original documents to a representative of the board for inspection. Original documents may include, but are not limited to, those listed in paragraph (2) of this subsection.

(2) Required documentation. Documentation required of all applicants for licensure shall include the following:

(A) Birth certificate/proof of age. Each applicant for licensure must provide a copy of either a birth certificate and translation, if necessary, to prove that the applicant is at least 21 years of age. In instances where a birth certificate is not available, the applicant must provide copies of a passport or other suitable alternate documentation.

(B) Name change. Any applicant who submits documentation showing a name other than the name under which the applicant has applied must present copies of marriage licenses, divorce decrees, or court orders stating the name change. In cases where the applicant's name has been changed by naturalization the applicant must submit the original naturalization certificate by hand delivery or by certified mail to the board office for inspection.

(C) Examination scores. Each applicant for licensure must have a certified transcript of grades submitted directly from the appropriate testing service to the acupuncture board for all examinations used in Texas for purposes of licensure in Texas.

(D) Dean's certification. Each applicant for licensure must have a certificate of graduation submitted directly from the school of acupuncture on a form provided by the acupuncture board. The applicant shall attach to the form a recent photograph, meeting United States Government passport standards, before submitting it to the school of acupuncture. The school shall have the Dean or the designated appointee sign the form attesting to the information on the form and placing the school seal over the photograph.

(E) Diploma or certificate. All applicants for licensure must submit a copy of their diploma or certificate of graduation.

(F) Evaluations. All applicants must provide, on a form furnished by the acupuncture board, evaluations of their professional affiliations for the past ten years or since graduation from acupuncture school, whichever is the shorter period.

(G) Preacupuncture school transcript. Each applicant must have the appropriate school or schools submit a copy of the record of their undergraduate education directly to the acupuncture board. Transcripts must show courses taken and grades obtained. If determined that the documentation submitted by the applicant is not sufficient to show proof of the completion of 60 semester hours of college courses other than in acupuncture school, the applicant must obtain coursework verification by submitting documentation to the acupuncture board for a determination as to the adequacy of such education or to a two or four year institution of higher education within the United States. The institution must be preapproved by the board's executive director and accredited by an agency recognized as a regional accrediting body by the Texas Higher Education Coordinating Board or its equivalent in another state.

(H) School of acupuncture transcript. Each applicant must have his or her acupuncture school submit a transcript of courses taken and grades obtained directly to the acupuncture board. Transcripts must clearly demonstrate completion of 1,800 instructional hours, with at least 450 hours of herbal studies.

(I) Fingerprint card. Each applicant must complete a fingerprint card for the Texas Department of Public Safety and return it to the acupuncture board as part of the application.

(J) Other verification. For good cause shown, with the approval of the acupuncture board, verification of any information required by this subsection may be made by a means not otherwise provided for in this subsection.

(3) Additional documentation. Applicants may be required to submit other documentation, including but not limited to the following:

(A) Translations. An accurate certified translation of any document that is in a language other than the English language along with the original document or a certified copy of the original document which has been translated.

(B) Arrest Records. If an applicant has ever been arrested, a copy of the arrest and arrest disposition from the arresting authority and submitted by that authority directly to the acupuncture board.

(C) Malpractice. If an applicant has ever been named in a malpractice claim filed with any liability carrier or if an applicant has ever been named in a malpractice suit, the applicant shall submit the following:

(i) a completed liability carrier form furnished by the acupuncture board regarding each claim filed against the applicant's insurance;

(ii) for each claim that becomes a malpractice suit, a letter from the attorney representing the applicant directly to this board explaining the allegation, dates of the allegation, and current status of the suit. If the suit has been closed, the attorney must state the disposition of the suit, and if any money was paid, the amount of the settlement, unless release of such information is prohibited by law or an order of a court with competent jurisdiction. If such letter is not available, the applicant will be required to furnish a notarized affidavit explaining why this letter cannot be provided; and

(iii) a statement, composed by the applicant, explaining the circumstances pertaining to patient care in defense of the allegations.

(D) Inpatient treatment for alcohol/substance abuse or mental illness. Each applicant that has been admitted to an inpatient facility within the last five years for the treatment of alcohol/substance abuse or mental illness must submit the following:

(i) an applicant's statement explaining the circumstances of the hospitalization;

(ii) an admitting summary and discharge summary, submitted directly from the inpatient facility;

(iii) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(iv) a copy of any contracts or agreements signed with any licensing authority.

(E) Outpatient treatment for alcohol/substance abuse or mental illness. Each applicant that has been treated on an outpatient basis within the last five years for alcohol/substance abuse or mental illness must submit the following:

(i) an applicant's statement explaining the circumstances of the outpatient treatment;

(ii) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(iii) a copy of any contracts or agreements signed with any licensing authority.

(F) Additional documentation. Additional documentation as is deemed necessary to facilitate the investigation of any application for licensure.

(G) DD214. A copy of the DD214 indicating separation from any branch of the United States military.

(H) Other verification. For good cause shown, with the approval of the acupuncture board, verification of any information required by this subsection may be made by a means not otherwise provided for in this subsection.

(I) False documentation. Falsification of any affidavit or submission of false information to obtain a license may subject an acupuncturist to denial of a license or to discipline pursuant to the Act, §205.351.

(4) Substitute documents/proof. The acupuncture board may, at its discretion, allow substitute documents where proof of exhaustive efforts on the applicant's part to secure the required documents is presented. These exceptions are reviewed by the acupuncture board, a board committee, or the board's executive director on an individual case-by-case basis.

(d) Temporary license.

(1) Issuance. The acupuncture board may, through the executive director of the agency, issue a temporary license to a licensure applicant who appears to meet all the qualifications for an acupuncture license under the Act, but is waiting for the next scheduled meeting of the acupuncture board for review and for the license to be issued.

(2) Duration/renewal. A temporary license shall be valid for 100 days from the date issued and may be extended only for another 30 days after the date the initial temporary license expires. Issuance of a temporary license may be subject to restrictions at the discretion of the executive director and shall not be deemed dispositive in regard to the decision by the acupuncture board to grant or deny an application for a permanent license.

(e) Distinguished professor temporary license.

(1) Issuance. The acupuncture board may issue a distinguished professor temporary license to an acupuncturist who:

(A) holds a substantially equivalent license, certificate, or authority to practice acupuncture in another state, province, or country; and

(B) agrees to and limits any acupuncture practice in this state to acupuncture practice for demonstration or teaching purposes for acupuncture students and/or instructors, and in direct affiliation with an acupuncture school that is a candidate for accreditation or has accreditation through the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) at which the students are trained and/or the instructors teach; and

(C) agrees to and limits practice to demonstrations or instruction under the direct supervision of a licensed Texas acupuncturist who holds an unrestricted license to practice acupuncture in this state; and

(D) pays any required fees for issuance or renewal of the distinguished professor temporary license.

(2) Duration. The distinguished professor temporary license shall be valid for a continuous one-year period; however, the permit is revocable at any time the board deems necessary. The distinguished professor temporary license shall automatically expire one year after the date of issuance. The distinguished professor temporary license may not be renewed or reissued.

(3) Disciplinary action. A distinguished professor temporary license or renewal may be denied, terminated, cancelled, suspended, or revoked for any violation of acupuncture board rules or the Act, Subchapter H.

(f) Relicensure. If an acupuncturist's license has been expired for one year, it is considered to have been canceled, and the acupuncturist may not renew the license. The acupuncturist may obtain a new license by complying with the requirements and procedures for obtaining an original license.

(g) Approved schools. An ACAOM approved acupuncture school may use the word "college" as a means of representation to the public as long as it maintains ACAOM accreditation. An approved school may not represent itself as a university.

(h) Exceptions. Before January 1, 2004, the acupuncture board may not adopt a rule under §205.101 of the Act, that requires a school of acupuncture operating in Texas on or before September 1, 1993, be accredited by, or a candidate for accreditation by, the ACAOM.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405314
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: October 3, 2004
For further information, please call: (512) 305-7016

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CHAPTER 199. PUBLIC INFORMATION

22 TAC §§199.2 - 199.4

The Texas State Board of Medical Examiners proposes amendments to §§199.2 - 199.4, concerning Public Information. The amendments are necessary for general cleanup of these sections.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners contemporaneously proposes the rule review of Chapter 199.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the rules are in effect there will be no fiscal implications to state or local government as a result of enforcing the rules as proposed. There will be no effect to individuals required to comply with the sections as proposed.

Ms. Shackelford also has determined that for each year of the first five years the rules as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be updated rules. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The amendments are proposed under the authority of the Occupations Code Annotated, §154.001 and §154.005 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§199.2. Requests to Speak.

(a) To provide the public with a reasonable opportunity to appear before the board and to speak regarding issues under the board's jurisdiction except as otherwise designated by these rules, written requests to speak may be submitted to the attention of the Public Information/Profile Committee at the board's current mailing address. Such request should be received no later than 10 business days prior to the board meeting at which the requestor wishes to speak.

(b) A requester will be notified in writing of the date and time for an opportunity to appear and speak before the Public Information/Profile Committee. The time allotted for any particular speaker will be determined in the discretion of the chairman or presiding member of the committee based on the subject matter and available time.

(c) The Public Information/Profile Committee shall make any necessary recommendations to the board regarding matters brought to the committee's attention by the public and shall report matters of interest to the board through the committee minutes.

§199.3. Requests for Information.

(a) The public may obtain copies of board newsletters, brochures, pamphlets, press releases and other board publications by written request to the attention of the Public Information/Profile Committee at the board's current mailing address or by electronic mail to the public information officer.

(b) Public records of the board may be obtained to the extent allowed by law through a written request pursuant to the Public Information [~~open records~~] Act of Texas submitted to the attention of the Manager, Public Information at the board's current mailing address, by fax, or by electronic mail to the board's designated email address.

(c) The provision of written materials or records provided pursuant to a request made under this chapter shall be subject to applicable charges under this title and state law.

§199.4. Charges for Copies of Public Records.

(a) Charges. The charge to any person requesting copies of any public record of the Texas State Board of Medical Examiners will be the charges established by the Texas Building and Procurement Commission [~~General Services Commission~~].

(b) Routine items. All charges for routinely requested items shall be based upon the charges established by the Texas Building and Procurement Commission [~~General Services Commission~~]. A current price list may be requested from the Customer Affairs Division of the Board. Upon written request, the board shall provide copies of routinely requested items, which shall include, but not be limited to, the following:

(1) Board Rules;

(2) Medical Practice Act;

(3) Microfiche with complete physician information:

(A) individual order;

(B) year subscription;

(4) New Physician List:

(A) list;

(B) year subscription;

(5) Physician Directory;

(6) Special Request:

(A) customized mailing list and labels;

(B) computer/electronic media:

(i) computer tape;

(ii) floppy disk.

(c) Certified copies. Upon written request, the Texas State Board of Medical Examiners will certify any public records of the board. The cost for certifying copies of public records provided pursuant to the Texas Open Records Act shall be $5.00 per record or document. This cost shall be in addition to any other costs charged for providing the requested document or record, including, but not limited to, copying, retrieving, or mailing of the document or record.

(d) Waiver of charges. Copies of public records shall be furnished without charge or at a reduced charge if the executive director determines that waiver or reduction of the fee is in the public interest, and that furnishing the information can be considered as primarily benefiting the general public.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 23, 2004. ♦ ♦ ♦

TRD-200405315
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
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For further information, please call: (512) 305-7016

WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 19. EDUCATION

PART 7. STATE BOARD FOR EDUCATOR CERTIFICATION

CHAPTER 230. PROFESSIONAL EDUCATOR PREPARATION AND CERTIFICATION

SUBCHAPTER U. ASSIGNMENT OF PUBLIC SCHOOL PERSONNEL

19 TAC §230.601

The State Board for Educator Certification has withdrawn from consideration the proposed amendment to §230.601 which appeared in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6495).

Filed with the Office of the Secretary of State on August 18, 2004.

TRD-200405235
Herman L. Smith, Ph.D.
Executive Director
State Board for Educator Certification
Effective date: August 18, 2004
For further information, please call: (512) 936-8239

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CHAPTER 233. CATEGORIES OF CLASSROOM TEACHING CERTIFICATES

19 TAC §233.9

The State Board for Educator Certification has withdrawn from consideration the proposed amendment to §233.9 which appeared in the July 16, 2004, issue of the *Texas Register* (29 TexReg 6870).

Filed with the Office of the Secretary of State on August 18, 2004.

TRD-200405236
Herman L. Smith, Ph.D.
Executive Director
State Board for Educator Certification
Effective date: August 18, 2004
For further information, please call: (512) 936-8239

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TITLE 22. EXAMINING BOARDS

PART 9. TEXAS STATE BOARD OF MEDICAL EXAMINERS

CHAPTER 163. LICENSURE

22 TAC §163.1

The Texas State Board of Medical Examiners has withdrawn from consideration the proposed amendments to §163.1 which appeared in the May 14, 2004, issue of the *Texas Register* (29 TexReg 4718).

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405305
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Effective date: August 23, 2004
For further information, please call: (512) 305-7016

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CHAPTER 171. POSTGRADUATE TRAINING PERMITS

22 TAC §§171.1 - 171.7

The Texas State Board of Medical Examiners has withdrawn from consideration the proposed repeal of §§171.1 - 171.7 which appeared in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6193).

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405308
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Effective date: August 23, 2004
For further information, please call: (512) 305-7016

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CHAPTER 171. POSTGRADUATE TRAINING AND PERMITS

22 TAC §§171.1 - 171.12

The Texas State Board of Medical Examiners has withdrawn from consideration the proposed new §§171.1 - 171.12 which appeared in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6194).

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405309

Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Effective date: August 23, 2004
For further information, please call: (512) 305-7016

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CHAPTER 192. OFFICE-BASED ANESTHESIA

22 TAC §192.1, §192.2

The Texas State Board of Medical Examiners has withdrawn from consideration the proposed amendment to §192.1 and §192.2 which appeared in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6204).

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405301
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
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For further information, please call: (512) 305-7016

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ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the the rule (Government Code, §2001.036). If a rule is adopted without change to the text as published in the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 7. BANKING AND SECURITIES

PART 1. FINANCE COMMISSION OF TEXAS

CHAPTER 1. CONSUMER CREDIT REGULATION

SUBCHAPTER F. ALTERNATE CHARGES FOR CONSUMER LOANS

7 TAC §1.601

The Finance Commission of Texas (commission) adopts amendments to §1.601, concerning authorized charges. The purpose of the amendments is to correct citation references that have changed as a result of legislative action. The amendments are adopted without changes to the proposal as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6175).

The commission received no written comments on the proposal.

The amendments are adopted under Texas Finance Code §11.304, which authorizes the commission to adopt rules to enforce Title 4 of the Texas Finance Code. Additionally, Texas Finance Code §342.551 authorizes the commission to adopt rules for the enforcement of the consumer loan chapter.

The statutory provision (as currently in effect) affected by the adopted amendments is Texas Finance Code §342.302.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Leslie L. Pettijohn
Commissioner
Finance Commission of Texas
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For further information, please call: (512) 936-7640

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SUBCHAPTER G. INTEREST AND OTHER CHARGES ON SECONDARY MORTGAGE LOANS

7 TAC §1.706

The Finance Commission of Texas (commission) adopts amendments to §1.706, concerning amounts authorized to be collected on or before closing. The purpose of the amendments is to correct citation references that have changed as a result of legislative action. The amendments are adopted without changes to the proposal as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6175).

The commission received no written comments on the proposal.

The amendments are adopted under Texas Finance Code §11.304, which authorizes the commission to adopt rules to enforce Title 4 of the Texas Finance Code. Additionally, Texas Finance Code §342.551 authorizes the commission to adopt rules for the enforcement of the consumer loan chapter.

The statutory provision (as currently in effect) affected by the adopted amendments is Texas Finance Code §342.302.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER I. INSURANCE

7 TAC §1.805, §1.808

The Finance Commission of Texas (commission) adopts amendments to §1.805 and §1.808, concerning authorized credit insurance, and termination and refund. The purpose of the amendments is to correct citation references that have changed as a result of legislative action. The amendments are adopted without changes to the proposal as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6176).

The commission received no written comments on the proposal.

The amendments are adopted under Texas Finance Code §11.304, which authorizes the commission to adopt rules to enforce Title 4 of the Texas Finance Code. Additionally, Texas Finance Code §342.551 authorizes the commission to adopt rules for the enforcement of the consumer loan chapter.

The statutory provision (as currently in effect) affected by the adopted amendments is Texas Finance Code §342.302.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER T. MOTOR VEHICLE SALES FINANCE OPERATIONS

7 TAC §1.1501, §1.1502

The Finance Commission of Texas (the commission) adopts new 7 TAC §1.1501 and §1.1502, relating to prepaid maintenance agreements of a motor vehicle. The purpose of the proposed new 7 TAC §1.1501 and §1.1502 is to define prepaid maintenance agreements and contracts and outline the usage and disclosure of the agreements as sold in connection with motor vehicles. The new rule is adopted with changes to the proposal as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6176).

Section 1.1501 defines a prepaid maintenance agreement and service contract.

Section 1.1502 outlines the methods of disclosure on a retail installment sales contract for prepaid maintenance agreements sold in connection with motor vehicles. Prepaid maintenance agreements that are required or otherwise included with the sale of a motor vehicle must be disclosed as a component of the cash price. Those agreements sold on a voluntary basis may be disclosed under two methods specified in the rule.

The commission received one written comment on the proposed rule from Karen Coffey, Chief Counsel, Texas Automotive Dealers Association.

The commenter requested that the definition of "Prepaid Maintenance Agreement" be modified to reflect the precise definition contained in the *Service Contract Provider Act,* Chapter 1304 of the Texas Occupations Code. The commission agrees to remove the referenced language from the definition section, but places a subset of the language in another section of the rule (7 TAC §1.1502(c)) instead of deleting it. The commission also notes that maintenance agreements are not covered by the requirements of Chapter 1304. This rule does not intend to modify or change the existing exemption of maintenance agreements from the requirements of Chapter 1304.

The commenter also objects that the rule include a "reasonable" cost requirement. The commenter contends that the addition of this requirement may increase litigation and that the standard is vague. The commission has redrafted the language to clearly provide the agency the ability to evaluate the charge of the prepaid maintenance agreements. This change should address the commenter's concerns about the rule creating private litigation. The charge for the prepaid maintenance agreement cannot be used as a subterfuge for obtaining hidden finance charge and the current draft of the rule clearly allows the agency to review the charge for the prepaid maintenance agreements for that purpose. The agency strongly believes that charges for prepaid maintenance agreements be reasonable. By modifying the rule, the commission believes it is making the standards needed for appropriate agency enforcement while addressing the commenter's concerns.

The commenter also objected to the use of the word "all" in 7 TAC §1.1502(a) because of the difficulty in determining whether the purchase is required or voluntary. The commission has modified the section so that it maintains the original intent but addresses the commenter's objection.

The rules are adopted under Texas Finance Code §11.304, which authorizes the commission to adopt rules to enforce Title 4 of the Texas Finance Code.

The statutory provision (as currently in effect) affected by the adopted rules is Texas Finance Code §348.

§1.1501. Definitions.

(a) Prepaid Maintenance Agreement--a maintenance agreement as defined in Section 1304.004, Texas Occupations Code.

(b) Service Contract--has the meaning assigned in Section 1304.003, Texas Occupations Code. Pursuant to Section 1304.004, Texas Occupations Code, a prepaid maintenance agreement is a type of service contract.

§1.1502. Prepaid Maintenance Agreements.

(a) If the prepaid maintenance agreement is required in connection with the sale of a motor vehicle, regardless of whether the sale is a cash sale or a credit sale, the charge for the prepaid maintenance agreement should be disclosed or otherwise included as a component of the cash price.

(b) If the prepaid maintenance agreement is offered as a voluntary purchase in connection with the credit sale of a motor vehicle, the prepaid maintenance agreement may be disclosed:

(1) as a component of the cash price; or

(2) as an itemized charge on the retail installment sales contract.

(c) At the time of the sale, the services covered by the prepaid maintenance agreement should be reasonably expected to be delivered during the term of the agreement.

(d) The agency may evaluate the assessed charge for a prepaid maintenance agreement. If the agency determines that the charge is excessive considering relevant factors, then the agency may consider the excessive amount as finance charge. One of the relevant factors the agency will consider is whether the assessed charge and sales representations between cash and credit transactions differ.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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PART 2. TEXAS DEPARTMENT OF BANKING

CHAPTER 25. PREPAID FUNERAL CONTRACTS

SUBCHAPTER B. REGULATION OF LICENSES

7 TAC §25.23

The Finance Commission of Texas (commission) adopts an amendment to §25.23, concerning application and renewal fees. The amendment to §25.23(b)(1) is adopted without changes to the proposed text as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6177) and will not be republished.

The amendment to §25.23(b)(1) decreases the new prepaid funeral contract permit application fee from $2,500 to $500. The fee decrease is appropriate because technological and procedural improvements have enabled the Texas Department of Banking (department) to increase its administrative efficiency and, as a result, operational costs in processing new permit applications have decreased significantly. Notwithstanding this fee decrease, the prepaid funeral contract regulatory program will continue to generate sufficient revenue to fully fund the costs of administering Finance Code, Chapter 154.

The commission received no comments regarding the proposed amendment.

The amendment to §25.23(b)(1) is adopted under Finance Code, §154.051, which authorizes the commission to adopt reasonable rules concerning fees to defray the cost of administering Finance Code, Chapter 154.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
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Texas Department of Banking
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CHAPTER 29. SALE OF CHECKS ACT

7 TAC §§29.1, 29.2, 29.4, 29.11, 29.21

The Finance Commission of Texas (commission) adopts the repeal of Chapter 29, specifically §§29.1, 29.2, 29.4, 29.11 and 29.21, concerning the Sale of Checks Act, without changes to the proposal as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6178).

In February 2004, the commission completed its review of Chapter 29 as required by Government Code, §2001.039, and readopted §§29.1, 29.2, 29.4, 29.11 and 29.21. As a result of the review, the commission identified certain clarifying and updating revisions to the chapter that were necessary and several new sections that needed to be added.

The commission has rewritten existing Chapter 29 to incorporate the necessary and appropriate revisions, and several of the existing sections have been extensively reorganized and rewritten in accordance with plain language writing principles. Because the Texas Register requires rules that are substantially revised or rewritten to be repealed and proposed as new rules, the commission is repealing existing Chapter 29 in its entirety. The commission is simultaneously adopting a new Chapter 29 in this issue of the *Texas Register*.

The commission received no comments regarding the proposed repeal.

The repeal is adopted under Finance Code, §152.102, which authorizes the commission to adopt rules necessary to enforce and administer Finance Code, Chapter 152.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
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7 TAC §§29.1 - 29.12

The Finance Commission of Texas (commission) adopts a new Chapter 29, relating to Finance Code, Chapter 152, the Sale of Checks Act. The adopted new chapter consists of §29.1, concerning permissible investments; §29.2, concerning fees, assessments and reimbursements; §29.3, concerning application for new sale of checks license; §29.4, concerning violation of application processing times; §29.5, concerning conduct of business through agent; §29.6, concerning net worth and bonding requirements for a license holder that conducts currency exchange, transportation or transmission transactions; §29.7, concerning exemption from licensing; §29.8, concerning license renewal; §29.9, concerning extension of time to file annual financial statement; §29.10, concerning correction of violations and imposition of administrative penalty; §29.11, concerning reporting and recordkeeping; and §29.12, concerning notice to customers regarding complaints. The commission adopts new §29.5 with nonsubstantive changes to the proposed text as published in the July 2, 2004, issue of the Texas Register (29 TexReg 6179). New §§29.1 - 29.4 and §§29.6 - 29.12, are adopted without changes to the previously published proposal.

For the reasons explained in this preamble, the commission is simultaneously adopting the repeal of existing Chapter 29 in this issue of the *Texas Register*.

Earlier this year, the commission completed its review of existing Chapter 29 as required by law and readopted §§29.1, 29.2, 29.4, 29.11 and 29.21. As a result of its review, however, the commission determined that certain clarifying and updating revisions to the chapter were necessary and that several new sections needed to be added, and the Texas Department of Banking (department) undertook a comprehensive drafting project. Chapter 29 was rewritten to reflect and incorporate the changes,

and several of the existing sections were extensively reorganized and rewritten in accordance with plain language writing principles. Because the *Texas Register* requires rules that are substantially revised or rewritten to be repealed and proposed as new rules, the commission simultaneously proposed to repeal existing Chapter 29 and proposed the revisions as sections in a new Chapter 29. The commission is now repealing existing Chapter 29 simultaneously with this adoption of proposed new Chapter 29. In this preamble, the term "former" is used to refer to Chapter 29 and its constituent sections that are being repealed.

For the most part, the differences between new Chapter 29 and the former chapter are nonsubstantive. The revisions to prior sections conform the terminology and statutory references to current law, eliminate redundancies, use more direct language, and clarify and simplify requirements and procedures. The sections that are being added generally reflect requirements that the department currently applies in connection with its administration and enforcement of Finance Code, Chapter 152 (Chapter 152).

The adopted new chapter implements Chapter 152. Finance Code, §152.102, authorizes the commission to adopt rules necessary to enforce and administer the Act, including rules to implement and clarify the Act, establish fees to defray administration costs, create exemptions in appropriate circumstances and, subject to appropriate conditions, identify additional permissible investments, and protect the interests of check purchasers.

The commission received comments regarding only two of the proposed sections, §29.2, concerning fees, assessments, and reimbursements, and §29.5, concerning the conduct of business through an agent. This preamble will set out in sequential order the adopted new sections with respect to which no comments were received, and, if applicable, note the primary differences between the adopted new section and the corresponding former section. The preamble will then discuss §29.2 and §29.5 and summarize and respond to the comments.

Adopted new §29.1 identifies the types of investments, in addition to the securities and assets defined in Finance Code, §152.001(10), that are considered to be a "permissible investment" for purposes of satisfying the Act's minimum security requirements, and establishes related conditions. The adopted new section is substantively similar to former §29.1, but uses more direct language, eliminates unnecessary definitions and verbiage, and conforms its terminology and statutory references to current law. Additionally, adopted new §29.1 deletes several provisions of the former section that are unnecessary.

Adopted new §29.3 establishes the requirements an applicant for a new license under Finance Code, Chapter 152, must satisfy and departmental procedures for accepting, evaluating and granting or denying an application that are efficient, fair and predictable. The adopted new section is substantively similar to former §29.4, but uses more direct language, eliminates unnecessary verbiage, clarifies procedures, and is reorganized to clarify meaning and facilitate understanding.

Adopted new §29.4 sets out procedures relating to complaints regarding the department's violation of application processing times. These procedures, which were included as part of former §29.4, are required by Government Code, §2005.003. Adopted new §29.4 uses more direct and descriptive language than the former section, eliminates unnecessary verbiage and clarifies procedures.

Adopted new §29.6 relates to the net worth and bonding requirements that apply to a Chapter 152 license holder that conducts currency exchange, transportation or transmission transactions as defined in Finance Code, Chapter 153 (Chapter 153). The adopted new section reflects the department's practice and its interpretation of Chapter 152 and Chapter 153 and §4.7 of this title (relating to Bond Requirements and Deposits in Lieu of Bond). The new section requires a Chapter 152 license holder who engages in the currency exchange, transportation or transmission business to satisfy either the net worth and bonding requirements of Chapter 152 or Chapter 153, whichever is greater.

Adopted new §29.7 establishes specific exemptions from the Act's licensing requirements for the authorized federal or state branch or agency of a foreign bank and the agent of such an entity, and the agent of a federally insured financial institution. The foreign bank branch or agency exemption is similar to that recognized in Finance Code, §153.117(2), regarding persons who conduct currency exchange, transportation and transmission transactions. The agent exemption is consistent with informal and formal department practices and legal opinions that have extended the exemption for a federally insured financial institution established in Finance Code, §152.202(1), to an agent of such an institution. Adopted new §29.7 requires a federally insured financial institution, foreign bank branch, or foreign bank agency that conducts business through an agent exempt from licensing to enter into an agency agreement with the agent that complies with adopted new §29.5(b).

Adopted new §29.8, which reflects the department's existing procedures and requirements, sets out the actions a Chapter 152 license holder must take to renew its license. In addition to other requirements, the new section requires a license holder to be current on its payment of fees, assessments and travel reimbursements due the department as of the date the department receives the renewal application.

Adopted new §29.9 establishes the procedure a Chapter 152 license holder must follow to secure an extension for submitting its annual audited financial statement. Finance Code, §152.305(b), requires a license holder to file its annual audited financial statement with the department no later than June 30th of each year, but authorizes the commissioner to extend the statutory due date for good cause. Adopted new §29.9 requires a license holder seeking an extension to submit a written request to the commissioner, which the department must receive no later than June 30th, explaining in detail the reasons the extension is necessary and specifying the period for which the extension is sought.

Adopted new §29.10 establishes the department's procedures to secure appropriate corrective and preventive action for a violation of Chapter 152, or a rule or order adopted or issued under Chapter 152. The new section also establishes procedures for dealing with continuing and repeat violations. The adopted new section is similar to §4.9 of this title (regarding Misrepresentation of Correction and Enforcement Actions for Continuing and Repeat Violations), which applies to persons licensed under Chapter 153 to conduct the currency exchange, transportation and transmission business.

Adopted new §29.11 establishes reporting and recordkeeping requirements that apply to a Chapter 152 license holder that engages or has engaged in the business of currency exchange, transportation or transmission within the meaning of Chapter 153. These requirements apply only to such a license holder's exchange, transportation and transmission activities. They impose no new obligations, but simply formalize by rule the requirements the license holder must currently satisfy and are similar to those imposed by §4.3 of this title (regarding Reporting and

Recordkeeping) upon persons licensed or exempt from licensure under Chapter 153.

Adopted new §29.12 specifies the manner in which a Chapter 152 license holder provides consumers with information about how to file complaints with the department. The new section, which implements Finance Code, §11.307, is substantively similar to former §29.21, but uses more direct language, eliminates unnecessary verbiage, and includes clarifying definitions. Additionally, the adopted new section allows a license holder to use either the specific notice set out in the section or a notice that substantially conforms to the specified language and form. The adopted new section also describes alternative means of giving notice that are tailored to the different methods by which a license holder conducts business and interacts with customers. Finally, as does former §29.21, adopted new §29.12 provides that a license holder that conducts business through an agent is subject to enforcement sanctions if the agent does not post the notice required by the section.

The commission received comments regarding proposed new §29.2 and §29.5. As proposed, §29.2 establishes the fees, assessments and reimbursements that an applicant for a license under Chapter 152 or a license holder must pay and sets the dates the respective payments are due. These charges are authorized in and set in accordance with the Act to reasonably approximate the department's costs in administering the Act generally or with respect to a particular filing. The proposal, which is substantively similar in most respects to former §29.2, uses more direct language, eliminates unnecessary verbiage, and is reorganized to clarify meaning and facilitate understanding. Further, the proposal does not increase the amount of any fee, assessment or reimbursement established in or required by former §29.2.

Unlike the former section, however, proposed §29.2 requires a license holder to pay its annual license renewal fee and assessments by ACH debit if directed to do so by the department. Proposed §29.2(c)(2) and (d)(1)(B) authorize the department to initiate an ACH debit of the license holder's bank account to collect, respectively, the annual renewal fee and annual assessment. The Non-Bank Funds Transmitters Group (Group), comprised of six national money transmitters that do business and are licensed in Texas, jointly submitted comments through their counsel objecting to any provision that would require a license holder to allow a third party, even the department, to have access to its bank account through an ACH debit. The Group argues that such access would create safety and soundness issues because of the possibility of mistakes, such as a misplaced decimal or inadvertent additional "0," that could materially affect a license holder's operations. Further, the Group asserts that the requirement would involve additional reconciliation and monitoring costs and is unnecessary. The commission also received an informal comment from an unidentified license holder expressing similar concerns, stating further that maintenance of a separate bank account used exclusively for purposes of the ACH debit would be too costly. The commenter suggested that license holders initiate their own ACH debits to the department.

The commission has carefully considered the comments and disagrees that the proposal to authorize the department to require payment by department-initiated ACH debit should be eliminated or revised. For the past several years, the department has collected assessments from state-chartered banks by ACH debit. Based upon that experience, the commission believes that department-initiated ACH debits represent a more efficient and effective means of collecting annual fees and, indeed, intends to eventually apply the ACH debit requirement to all categories of entities regulated by the department. Collection by department-initiated ACH debit virtually eliminates the processing of incoming payments. The system requires little, if any, reconciliation with respect to the amount a license holder owes, whether payment has been received, and the actual amount paid. The commission believes that the collection of payments through department-initiated ACH debit will enable the department to streamline its operational procedures and thereby save administrative time and reduce costs. These benefits are most likely to be realized if the department, not the license holder, initiates the debit.

The commission also disagrees that a department-initiated ACH debit raises safety and soundness issues. The commission is not aware of any problems state-chartered banks have experienced as a result of the ACH debit procedure, or of any instance in which an error occurred with respect to the amount actually debited. Significantly, both the Federal Deposit Insurance Corporation and the Office of the Comptroller of the Currency require United States banks to pay their FDIC insurance premiums and semi-annual assessments, respectively, through ACH debit initiated by those regulators.

Moreover, the department intends to use the same procedures it has developed to collect state bank assessments through ACH debit to collect the assessments and fees due from its Chapter 152 license holders. Under these procedures, a license holder will complete an authorization form that permits the department to debit the designated account for purposes of collecting the assessment or renewal fee. Approximately two weeks before the payment is due and the account is to be debited, the department will send the license holder a notice of the amount of the assessment or fee and the exact date on which the debit will occur, which will give the license holder time to arrange to have sufficient funds in the account to honor the debit. Prior to initiating the debit, an internal review process will be followed to ensure that the correct amount is ordered to be debited.

In light of the department's considerable experience with ACH debits and the procedures the department has developed and will follow to effect debits from the accounts of its Chapter 152 license holders, the commission does not believe that the proposed ACH debit requirement creates safety and soundness issues. However, a license holder concerned about third-party access to its primary bank account has the option of establishing, for what we would expect to be a minimal fee, a separate account used solely for the funding of the ACH debits.

Because the commission believes that proposed §29.2(c)(2) and (d)(1)(B) are necessary to and will promote the department's operational efficiency in collecting annual renewal fees and assessments, saving administrative time and reducing costs, and will not in any way jeopardize the safety and soundness of its Chapter 152 license holders, the commission adopts new §29.2(c)(2) and (d)(1)(B) as proposed.

Proposed new §29.5 establishes certain requirements that apply to a Chapter 152 license holder that conducts business through an agent. The proposal, which clarifies the department's existing practices toward and review of such a license holder, requires the license holder to enter into a written agreement with each agent that appoints the agent and sets out the respective rights and responsibilities of the parties and is signed by them. As proposed,

§29.5(a) also requires the license holder to adopt certain minimum written policies and practices relating to the agency relationship. The Group suggests that §29.5(a) not apply to license holders' agents that are depository institutions, such as banks and savings and loan associations, because of the extent to which such institutions are already regulated by state and federal agencies. The commission agrees and has amended §29.5(a) to exclude certain federally insured financial institutions and foreign bank branches and agencies. Because the amendment to the section regulates no new parties, affects no new subjects of regulation, and is the result of public comment, the commission concludes that the amendment is nonsubstantive and does not require reproposal.

The new sections are adopted under Finance Code, §152.102, which authorizes the commission to adopt rules necessary to enforce and administer the Act, including rules to implement and clarify the Act, establish fees to defray administration costs, create exemptions in appropriate circumstances and subject to appropriate conditions, identify additional permissible investments, and protect the interests of check purchasers. The new sections are also proposed under Finance Code, §152.002(10)(C), which authorizes additional permissible investments as permitted by rule, §152.202(7), which authorizes persons to be exempted by rule from the licensing requirements of Chapter 152, and §152.205(1) and §152.304(a), which provide for the establishment by rule of the amount of license application and annual license renewal fees.

Finance Code, Chapter 152 is affected by the adopted new sections.

§29.5. Conduct of Business Through Agent.

(a) Written policies and practices. A license holder that conducts business through an agent must adopt written policies and practices relating to its agent relationships, unless the agent is a federally insured financial institution exempt under Finance Code, §152.202(a)(1), or a foreign bank branch or agency exempt under §29.7(a)(1) of this title (relating to Exemption from Licensing). At a minimum, the policies and practices must address:

(1) agent selection criteria;

(2) loss prevention;

(3) regulatory compliance training; and

(4) agent monitoring.

(b) Written agreement. Before a license holder may conduct business through an agent, the license holder and agent must enter into a written agreement appointing the agent and setting out the respective rights, responsibilities, duties and liabilities of the parties. The agreement must be signed by the license holder and agent or their duly authorized representatives. At a minimum, the agreement must include terms that reflect or incorporate the applicable requirements of Finance Code, §152.403 and §152.404, and specifically require the agent to comply with the notice posting requirements of §29.12 of this title (relating to Notice to Customers Regarding Complaints).

(c) Retention of agent agreements. A license holder must retain the original or a true and correct copy of each agent agreement and make each agreement available for examination by the department.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
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TITLE 10. COMMUNITY DEVELOPMENT

PART 6. OFFICE OF RURAL COMMUNITY AFFAIRS

CHAPTER 255. TEXAS COMMUNITY DEVELOPMENT PROGRAM

SUBCHAPTER A. ALLOCATION OF PROGRAM FUNDS

10 TAC §255.10, §255.14

The Office of Rural Community Affairs (Office) adopts amendments to §255.10 and new §255.14, concerning the allocation of Community Development Block Grant (CDBG) non-entitlement area funds under the Texas Community Development Program (TCDP). New §255.14 is adopted with changes to the proposed text as published in the May 28, 2004, issue of the *Texas Register* (29 TexReg 5237). The amendments to §255.10 are adopted without changes to the proposed text and will not be republished.

The amendments establish the standards and procedures by which the Office will allocate and distribute 2004 fiscal years' funds under the housing infrastructure fund. The new section establishes the standards and procedures by which the Office will guarantee funds under the section 108 loan guarantee pilot program. The amendments are being adopted to make changes to the selection criteria for the housing infrastructure fund and to establish application and selection criteria for the new section.

No written comments were received on the amendments to §255.10 or for new §255.14.

The amendments and new section are adopted under §487.052 of the Government Code, which provides the Office of Rural Community Affairs with the authority to adopt rules implementing its statutory responsibilities.

The Texas Administrative Code, Title 10, Part 6, Chapter 255, is affected by the adoption of the amendments to §255.10 and the adoption of new §255.14.

§255.14. Section 108 Loan Guarantee Pilot Program.

(a) General Provisions. Section 108 is the loan guarantee provision authorized under section 108 of the Housing and Community Development Act (42 United States Code §§5301 et seq.). The loan is made by a private lender to an eligible community. The United States Department of Housing and Urban Development (HUD) guarantees the loan; however, TCDP must pledge the state's current and future Community Development Block Grant nonentitlement area funds to cover any losses. An eligible community would prepare a loan guarantee application for submission to HUD.

(b) Conditions. The following conditions apply under the TCDP Section 108 program:

(1) the Office will not provide a commitment for an application submitted to HUD for a Section 108 guarantee unless the Office has reviewed the application, conducted an underwriting analysis, and specifically recommended its approval;

(2) the Office will charge the eligible community receiving the Section 108 loan a non-refundable loan loss reserve fee at the rate of one percent per annum on the principal amount outstanding. The funds from the one percent fee would be used for any debt service payments the Office would need to pay on account of the loan, or to cover any loan losses, if the recipient does not make its Section 108 loan payments;

(3) the application must be only for an activity eligible under the TCDP;

(4) the Office will require the community to submit adequate information necessary to track all loan repayments made by any third party borrowers such as assisted businesses; and

(5) the Office will monitor compliance with program requirements.

(c) Eligible Activities.

(1) The project must meet a national objective of Housing and Community Development Act:

(A) principally benefit low- and moderate-income persons;

(B) aid in the elimination of slums or blight; or

(C) meet other community development needs of particular urgency which represent an immediate threat to the health and safety of residents of the community.

(2) In addition, the State program is specifically restricting eligibility to economic development activities eligible under the state Community Development Block Grant (CDBG) Program. Other activities eligible under the 24 Code of Federal Regulations Part 570 will not be eligible under the pilot phase of this program.

(d) Terms. The maximum repayment period for a Section 108 guaranteed loan under the TCDP will be twenty years. The TCDP will not establish a funded loss reserve. The Office anticipates entering into a Reimbursement Agreement with the community providing for recovery of amounts required to be paid by the TCDP. Should the TCDP be required to cover any Section 108 loan payments not made by the recipient of the loan guarantee, it would first use funds that have been collected from the additional one percent per annum fee charged on the loan.

(e) Pilot Program Application and Amount. In order to provide eligible communities an additional funding source, the TCDP is authorizing a loan guarantee pilot program consisting of one application up to a maximum of $500,000 for a particular project. Additional information on the selection criteria and underwriting thresholds will be provided in the application guide for applicants interested in being selected as the pilot project under this program.

(f) Application Review and Underwriting Analysis. The Office will review each complete application to make threshold determinations with respect to:

(1) whether the application meets the Section 108 eligibility requirements;

(2) whether the use of CDBG Section 108 loan guarantee funds is appropriate to carry out the project proposed in the application;

(3) the strength of commitments from all other public and/or private investments identified in the application;

(4) whether there is evidence that the permanent jobs created or retained will primarily benefit low-and-moderate income persons; and

(5) the financial feasibility of the business to be assisted, including reviews of appropriate projections of revenues, expenses, debt service and returns on equity investments in the project as described in subsection (g) of this section, Underwriting Analysis and Review, of this subsection. Generally, the project should demonstrate that it would generate a positive net present value of discounted cash flows.

(g) Underwriting Analysis and Review.

(1) Project costs are reasonable. The Office will review a breakdown of all project costs and that each cost element making up the project for reasonableness.

(2) Commitment of all project sources of financing. The Office will review all projected sources of financing necessary to carry out the economic development project to determine whether the proposal is ready to proceed. To the extent practicable, prior to the commitment of Section 108 CDBG funds to the project, the Office will verify that sufficient sources of funds have been identified to finance the project; all participating parties providing those funds have affirmed their intention to make the funds available; and the participating parties have the financial capacity to provide the funds.

(3) Avoid substitution of Section 108 CDBG funds for non-Federal financial support. The Office will review the economic development project to ensure that, to the extent practicable, CDBG funds will not be used to substantially reduce the amount of non-Federal financial support for the activity. The Office will review whether or not the business being assisted has applied for private debt financing from a commercial lending institution and whether that institution has completed all of its financial underwriting and loan approval actions resulting in either a firm commitment of its funds or a decision not to participate in the project.

(4) Financial feasibility of the project. The Office will evaluate the financial viability of the project. A project would be considered financially viable if:

(A) all of the assumptions about the project's market share, projections of revenue, projections of expenses, non-cash expenses, net income, and debt service, including the repayment of the Section 108 guaranteed loan, are determined to be realistic;

(B) it projects positive accumulated cash flow for the life of the project including cash from both operational and financial cash flows;

(C) it projects a debt service coverage ratio of 1.5 and cash flow coverage ratio of 1.25 by the 5th year; and

(D) it projects a return on equity by the 10th year of at least 400 basis points greater than the current rate for 30-year U.S. Treasury Bonds.

(5) Disbursement of Section 108 CDBG funds on a pro rata basis. To the extent practicable, the proceeds should be disbursed on a pro rata basis with other funding sources.

(h) Selection Criteria. Applications meeting threshold requirements of subsection (f) of this section will be scored based on the following:

(1) Community Need (Maximum of 30 points)

(A) Unemployment (maximum 10 points). Five points awarded if the applicant's unemployment rate is higher than the state

rate, indicating that the community is economically below the state average. Ten points awarded if the applicant's most recently available unemployment rate is 1.5% over the state rate. (For cities, the most recently available city rate will be used; for counties, the most recently available county or census tract rate, for where the business site is located, whichever is higher, will be used).

(B) Poverty (maximum 10 points). Awarded if the applicant's most recently available annual county poverty rate is higher than the annual state rate, indicating that the community is economically below the state average. Applicants will score 5 points if their rate meets or exceeds the state average and score 10 points if this figure exceeds the state average by at least 15%.

(C) Community Population (more Rural) (maximum 10 points). Points are awarded to applying cities with populations of 5,050 or less and counties with a total population of 35,000 or less, using 2000 census data. For cities: score 5 points if the city is located in a county with a population of 35,000 or less; and score 5 additional points if the population of the city is less than 5,050. For counties: score 5 points if the county population is less than 35,000 and score 5 additional points if the county population is less than 15,350.

(2) Jobs (Maximum of 20 points).

(A) Job Impact (Jobs Created or Retained per Population of Community) (Maximum 10 points). Awarded by taking the Business' total job commitment, created and retained, and dividing by applicant's 2000 unadjusted population. This equals the job impact ratio. Score 5 points if this figure exceeds the median job impact ratio for prior years; and score 10 points if this figure exceeds 200% of the ratio. County applicants should deduct the 2000 census population amounts for all incorporated cities, except in the case where the county is sponsoring an application for a business that is or will be located in an incorporated city. In this case the city's population would be used, rather than the county's.

(B) Cost per Job (Maximum 10 points). Awarded by dividing the amount of Section 108 loan guarantee amount requested by the number of full-time job equivalents to be created and/or retained. Points are then awarded in accordance with the following scale:

(i) Below $15,000--10 points.

(ii) Below $20,000--5 points.

(3) In the event of a tie score and insufficient funds to approve all applications, the following tie breaker criteria will be used.

(A) The tying applications are ranked from lowest to highest based on poverty rate stated on the score sheet. Thus, preference is given to the applicant with the higher poverty rate.

(B) If a tie still exists after applying the first criteria then applications are ranked from lowest to highest based on unemployment rate stated on the score sheet. Thus, preference is then given to the applicant with the higher unemployment rate.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405295

Robt. J. "Sam" Tessen
Executive Director
Office of Rural Community Affairs
Effective date: September 12, 2004
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For further information, please call: (512) 936-6710

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TITLE 16. ECONOMIC REGULATION

PART 8. TEXAS RACING COMMISSION

CHAPTER 303. GENERAL PROVISIONS

SUBCHAPTER D. TEXAS BRED INCENTIVE PROGRAMS

DIVISION 2. PROGRAM FOR HORSES

16 TAC §303.93

The Texas Racing Commission adopts an amendment to §303.93, relating to quarter horse rules. The amendment is adopted without changes to the proposal published in the June 25, 2004 issue of the *Texas Register* (29 TexReg 6021) and the amendment will not be republished.

The amendment clarifies the rule language regarding the accreditation requirements for multiple foals conceived in a single breeding. The proposal was presented to the Commission as a petition for rulemaking by the Texas Quarter Horse Association.

The amendment is adopted to provide greater clarification of the accreditation requirements for multiple quarter horse foals conceived in a single breeding.

No comments were received regarding the adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 179e, §3.02 which authorizes the Commission to make rules relating exclusively to horse and greyhound racing; and §6.08 which authorizes the Commission to adopt rules relating to the accounting, audit, and distribution of Texas Bred Incentive program funds.

The amendment implements Texas Civil Statutes, Article 179e.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 19, 2004.

TRD-200405251
Nicole Galwardi
General Counsel
Texas Racing Commission
Effective date: September 8, 2004
Proposal publication date: June 25, 2004
For further information, please call: (512) 490-4009

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CHAPTER 311. OTHER LICENSES

SUBCHAPTER A. LICENSING PROVISIONS

DIVISION 1. OCCUPATIONAL LICENSES

16 TAC §311.5

The Texas Racing Commission adopts an amendment to §311.5, relating to occupational license fees. The amendment is adopted without changes to the proposal published in the May 28, 2004 issue of the *Texas Register* (29 TexReg 5246) and the amendment will not be republished.

The amendment provides clarifying language regarding the methods available for payment of license fees.

The amendment is adopted to increase the flexibility in the payment options available for a licensee.

No comments were received regarding the adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 179e, §3.02 which authorizes the Commission to make rules relating exclusively to horse and greyhound racing; §5.01 which authorizes the Commission to issue licenses and set conditions for licenses; §7.03 which authorizes the Commission to issue occupational licenses; and Article 7 which authorizes the Commission to require, set conditions and qualifications for, issue, and deny occupational licenses.

The amendment implements Texas Civil Statutes, Article 179e.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TITLE 22. EXAMINING BOARDS

PART 9. TEXAS STATE BOARD OF MEDICAL EXAMINERS

CHAPTER 163. LICENSURE

22 TAC §163.15

The Texas State Board of Medical Examiners adopts new §163.15, concerning Visiting Physician Permit, without changes to the proposed text as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6193) and will not be republished.

The new rule concerns permits for applicants practicing under the supervision of a licensed Texas physician for educational purposes or providing charity care to underserved populations in Texas.

No comments were received regarding adoption of the rule.

The new section is adopted under the authority of the Occupations Code Annotated, §§153.001, 155.001-.002, and 155.104 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200405299
Donald W. Patrick, MD, JD
Executive Director
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Effective date: September 12, 2004
Proposal publication date: July 2, 2004
For further information, please call: (512) 305-7016

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CHAPTER 175. FEES, PENALTIES AND APPLICATIONS

22 TAC §175.1

The Texas State Board of Medical Examiners adopts an amendment to §175.1, concerning Fees, without changes to the proposed text as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6199) and will not be republished.

The amendment is related to increases in application and registration fees mandated by the Texas Online Authority and increase in physician-in-training fee relating to the length of the permit.

No comments were received regarding adoption of the rule.

The amendment is adopted under the authority of the Occupations Code Annotated, §153.001, and Texas Government Code §2054.252(g) which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 183. ACUPUNCTURE

22 TAC §183.2, §183.16

The Texas State Board of Medical Examiners adopts amendments to §183.2 and §183.16, concerning Definitions and Texas Acupuncture Schools, without changes to the proposed text as

published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6201) and will not be republished.

The amendments clarify that certificates and diplomas are acceptable for acupuncture licensure.

No comments were received regarding adoption of the rules.

The amendments are adopted under the authority of the Occupations Code Annotated, §§153.001, 205.203 and 205.206 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 190. DISCIPLINARY GUIDELINES
SUBCHAPTER D. ADMINISTRATIVE PENALTIES

22 TAC §190.16

The Texas State Board of Medical Examiners adopts new §190.16, concerning Administrative Penalties, with changes to the proposed text as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6204). The text of the rule will be republished.

The new rule concerns limits on the amount of administrative penalty assessed and describes the criteria on which the penalty is based.

The Texas State Board of Medical Examiners received the following comment from the Texas Medical Association (TMA). TMA expressed concern that subsection (b)(6) allows the board to address an administrative penalty based upon "the costs of administrative hearing....investigative costs, attorney and other staff time spent preparing and presenting the case, witness fees, deposition expenses, travel expenses of witnesses, transcription fees, costs of adjudication before SOAH and any other costs that are necessary for the preparation of the board's case including the costs of any transcriptions of testimony."TMA stated that imposition of such costs is outside the board's statutory authority as provided by Section 165.003 and as admitted to in the Board's own sunset self-evaluation from August 2003." TMA further stated that SB 104 allowed for a surcharge on all physicians to cover such costs of TSBME's enforcement program.

TSBME's response to the comment: Subsection (b)(6) should not be adopted.

The new rule is adopted under the authority of the Occupations Code Annotated, §153.001 and §§165.001-.008 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

§190.16. Administrative Penalties.

(a) The amount of an administrative penalty may not exceed $5,000 for each violation. Each day a violation continues or occurs is a separate violation for purposes of imposing a penalty.

(b) The amount of the penalty shall be based on:

(1) the seriousness of the violation, including;

(A) the nature, circumstances, extent, and gravity of any prohibited act; and

(B) the hazard or potential hazard created to the health, safety, or economic welfare of the public;

(2) the economic harm to property or the environment caused by the violation;

(3) the history of previous violations;

(4) the amount necessary to deter a future violation; and

(5) efforts to correct the violation.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
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CHAPTER 192. OFFICE-BASED ANESTHESIA

22 TAC §192.3, §192.4

The Texas State Board of Medical Examiners adopts amendments to §192.3 and §192.4, concerning Office-Based Anesthesia, without changes to the proposed text as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6204) and will not be republished.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners withdraws the amendments to §192.1 and §192.2, as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6204).

The amendments relate to the provision of anesthesia in outpatient settings, compliance with office-based anesthesia rules, and registration to include additional requirements for patient rights, emergency power sources, ancillary services, credentialing of personnel, peer review requirements, and registration requirements.

No comments were received regarding §192.3 and §192.4, however the following comments were received regarding §192.1 and §192.2:

1. Texas Association of Nurse Anesthetists (TANA)

Comment #1: 162.102(b) provides for the adoption of rules related to the provision of general anesthesia, regional anesthesia, and monitored anesthesia. The new definitions of deep/sedation/analgesia and moderate sedation/anesthesia under 192.1 need to be tied back to the types of anesthesia over which the TSBME is given authority in order to be consistent with statute

Response: These changes were made to be consistent with FSMB guidelines and with those set by the American Society of Anesthesiologists (ASA). The definitions are more consistent with types of anesthesia provided and are not in conflict with the intent of the statute. Monitored anesthesia care relates to the delivery of anesthesia (general, local, regional) by a variety of qualified anesthesia personnel and seems to relate more to a billing issue than the type of anesthesia being delivered as presumably all forms of anesthesia provided are monitored anesthesia care. No changes recommended based on these comments.

Comment #2: §162.103 of the MPA provides that rules adopted by TSBME do not apply to "outpatient settings in which only anxioloytics and analgesics are used and only in doses that do not have the probability of placing the patient at risk for the loss of the patient's life-preserving reflexes." Therefore TANA believes it is confusing to define "minimal sedation" as "(anxiolysis)" under 192.1(6).

Response: Again this change was made to be consistent with FSMB and ASA guidelines. More review is scheduled.

Comment #3: The addition of §192.2(c)(9) is contrary to the legislative intent in that it appears to limit the current scope of practice of a nurse anesthetist or the Board of Nurse Examiners' ability to regulate the practice of a nurse anesthetist.

Response: The intent was not to infringe on the scope of practice of CRNAs. With all other safeguards in place, staff recommends pulling §192.2(c)(9)

Comments #4-11: The revised rules were not coordinated with the BNE as required by statute and the proposed rules do not maintain the legislatively mandated separation of the TSBME's authority over physician practice relative to the BNE's authority over the practice of CRNAs. TANA recommends that no changes be made to §192.2(d), (e), (f), and (g). Changes are recommended so as to not interfere with the scope of practice of CRNAs.

Response: Staff recommends that BNE be given adequate time to review the proposed changes and that both boards work together on revisions. The language of subsection (d) should remain in light of Comment #3. Other provisions referenced are reorganized in the rest of the chapter but recommend that section be pulled so that staff can work in collaboration with BNE on these rules.

Comment #12: Language on emergency supplies under §192.2(i) that adds "including but not limited to" makes the rule less clear and is inconsistent with BNE rules regarding emergency supplies under §221.16(c)(4)

Response: Agree. Language should remain unmodified.

Comment #13: The new section 192.2(j) on ancillary services is not included in the BNE's rules and therefore are inconsistent although TANA does not object to the advisability of the rules.

Response: Staff recommends keeping this addition and encouraging BNE to adopt similar rules.

Comment #14: TANA objects to the proposed §§192.2(m) and (n) regarding credentialing and peer review in outpatient settings in that this rule purports to give the BME authority over nurse peer review which is regulated by the BNE and Nurse Peer Review Act.

Response: These provisions were proposed to ensure that physicians who maintain OBA sites ultimately responsible for verifying the credentials of their staff and have policies in place to handle peer review. Staff believes that these provisions are not in conflict but merely establishes that peer review must occur not by what methods.

2. Texas Nurse Association (TNA)

Comment #1: Medical board did not consult with BNE regarding proposed rules as required by statute.

Response: Agree. Collaboration with BNE is required and planned.

Comment #2: Proposed §192.2(g) may in fact restrict the existing practice of CRNAs.

Response: This section is a reorganization and staff believes the changes proposed do not change existing delegation requirements for CRNAs.

Comment #3: Agree with comments of the BNE.

Response: See responses to BNE comments.

3. Board of Nurse Examiners (BNE)

Overall Comment: Medical board did not consult with BNE regarding proposed rules as required by statute.

Response: Agree. Collaboration with BNE is required and planned.

Comment #1: Current rules were not conflicting and better understood then what was offered. Any changes require coordination of effort by the boards.

Response: The primary purpose of the changes was clarification. Staff agrees to pull all or some of the rules and work with BNE to find mutually agreeable language.

Comment #2: Consistent with TANA's Comments #1 and #2.

Response: Same as above.

Comment 3: Consistent with TANA's Comment #3.

Response: Same as above.

Comment #4: When rules were first drafted, the board agreed that each should retain jurisdiction over its own licensees in determining appropriate standards. Proposed changes to §192.2(d) would inappropriately require nurse anesthetists to comply with ASA guidelines. Suggest either deletion or clarify language to reflect that CRNAs, unlike physicians, will be required to comply with the requirements outlined in BNE rule and the standards set forth by the BNE.

Response: Agree

Comment #5: Requirements set out in §192.2(f)((5) that discharge criteria only occur when patients have met specific "physician-defined" criteria ignores the scope of practice of CRNAs. Propose deletion of term to allow for criteria to be defined jointly by the anesthesia provider in collaboration wit the physician performing the surgical procedure.

Response: Agree

Comment #6: Requirements contained in §192.2(f)(6)(B),(C), and (D) are not consistent with the requirements regarding monitoring of patients in the event of an electrical outage contained in 22 TAC §221.16(c)(2) of the BNE rules. Additional requirements make the rules inconsistent.

Response: Staff will work with BNE to find mutually agreeable language. Language under BNE's rules is as follows: In the event of an electrical outage which disrupts the capability to continuously monitor all specified patient parameters, at a minimum, heart rate and breath sounds will be monitored on a continuous basis using a precordial stethoscope or similar device, and blood pressure measurements will be reestablished using a non-electrical blood pressure measuring device until electricity is restored.

Comment #7: Proposed §192.2(g)(1)-(5) appears to outline functions that fall within the scope of practice of a CRNA, which should be left to the BNE.

Response: This language was merely restructured and the content is not new. Staff will work with BNE to find mutually agreeable language.

Comment #8: Proposed §192.2(j) regarding ancillary services is not consistent with current BNE rules.

Response: Staff believes the provisions are important and that staff should work with BNE so that they adopt similar standards. It is the physician who has opted to perform OBA services with the CRNA coming into the physician's office to provide services. Statute requires that the boards cooperate to the extent possible to eliminate conflicts but that shouldn't mean that this be used as a strong-arm tactic that prevents the BME from setting standards for its own licensees provided it doesn't infringe on licensees beyond its jurisdiction.

Comment #9: Consistent with TANA's Comment #14.

Response: Same as above.

The amendments are adopted under the authority of the Occupations Code Annotated, §153.001 and §§162.101-107 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to office-based anesthesia.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200405302
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
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For further information, please call: (512) 305-7016

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CHAPTER 193. STANDING DELEGATION ORDERS

22 TAC §193.11

The Texas State Board of Medical Examiners adopts an amendment to §193.11, Use of Lasers, regarding continuing education on the use of laser devices, with changes to the proposed text as published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6209). The text of the rule will be republished.

The Texas State Board of Medical Examiners received the following comments from the Texas Dermatological Society:

Comment: Supports proposed rule changes to subsections (h)(2) and (i)(4)

Comment: In subsection (f) should documentation and retention of training activities be maintained for the same time period that the physician would be required to maintain the treated patient's records that would include treatment by that person?

Response: Subsection (f) relates to requirements for use of alternate physicians. The comment is unrelated to the proposed change and it is unclear what existing language they would like the Board to amend. No changes recommended.

Comment: Amend language in (h)(2) to read as follows: "Maintain competence to perform non-ablative procedures through documented hours of annual training regarding the appropriate standard of care in the field of non-ablative procedures and the use of the specific device(s) operated."

Response: This is consistent with the intent of the rule change. Agree with modification and believe it would be nonsubstantive.

The amendment is adopted under the authority of the Occupations Code Annotated, §§153.001, 157.001 and 157.006 which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to physician delegation.

§193.11. Use of Lasers.

(a) Purpose. As the use of lasers/pulsed light devices is the practice of medicine, the purpose of this section is to provide guidelines for the use of these devices for ablative and non-ablative treatment by physicians. Nothing in these rules shall be construed to relieve the supervising physician of the professional or legal responsibility for the care and treatment of the physician's patients.

(b) Definitions. For the purpose of this section, the following definitions will apply.

(1) Advanced health practitioner--An advanced health practitioner is a physician assistant or an advanced practice nurse.

(2) Non-ablative treatment--Non-ablative treatment shall include any laser/intense pulsed light treatment that is not expected or intended to remove, burn, or vaporize the epidermal surface of the skin. This shall include treatments related to laser hair removal.

(3) On-site supervision--On-site supervision shall mean continuous supervision in which the individual is in the same building.

(4) Physician--A physician licensed by the Texas State Board of Medical Examiners.

(c) Use of lasers in the practice of medicine.

(1) The use of lasers/pulsed light devices for the purpose of treating a physical disease, disorder, deformity or injury shall constitute the practice of medicine pursuant to §151.002(a)(13) of the Medical Practice Act.

(2) The use of lasers/pulsed light devices for non-ablative procedures cannot be delegated to non-physician delegates, other than an advanced health practitioner, without the delegating/supervising physician being on-site and immediately available.

(3) The use of lasers/pulsed light devices for ablative procedures may only be performed by a physician.

(d) Delegation.

(1) If the physician provides on-site supervision, the physician may delegate the performance of non-ablative treatment through the use of written protocols to a properly trained delegate acting under adequate supervision.

(2) If the physician does not provide on-site supervision during a non-ablative treatment, the on-site supervision may be delegated to an advanced health practitioner.

(3) Prior to any non-ablative initial treatment, the physician or advanced health practitioner must examine the patient and sign the patient's chart.

(e) Supervision. Supervision by the delegating physician shall be considered adequate for purposes of this section if the physician is in compliance with this section and the physician:

(1) ensures that patients are adequately informed and have signed consent forms prior to treatment that outline reasonably foreseeable side effects and untoward complications that may result from the non-ablative treatment;

(2) is responsible for the formulation or approval of a written protocol and any patient-specific deviation from the protocol;

(3) reviews and signs, at least annually, the written protocol and any patient-specific deviations from the protocol regarding care provided to a patient under the protocol on a schedule defined in the written protocol;

(4) receives, on a schedule defined in the written protocol, a periodic status report on the patient, including any problems or complications encountered;

(5) remains on-site for non-ablative treatments performed by delegates consistent with subsection (d)(1) of this section and immediately available for consultation, assistance, and direction;

(6) personally attends to, evaluates, and treats complications that arise; and

(7) evaluates the technical skills of the delegate performing non-ablative treatment by documenting and reviewing at least quarterly the assistant's ability:

(A) to properly operate the devices and provide safe and effective care; and

(B) to respond appropriately to complications and untoward effects of the procedures.

(f) Alternate physicians.

(1) If a delegating physician will be unavailable to supervise a delegate as required by this section, arrangements shall be made for another physician to provide that supervision.

(2) The physician providing that supervision shall affirm in writing that he or she is familiar with the protocols or standing delegation orders in use at the site and is accountable for adequately supervising care provided pursuant to those protocols or standing delegation orders.

(3) An alternate physician must have the same training in performance of non-ablative treatments as the primary supervising physician.

(g) Written protocols. Written protocols for the purpose of this section shall mean a physician's order, standing delegation order, standing medical order, or other written order that is maintained on site. A written protocol must provide at a minimum the following:

(1) a statement identifying the individual physician authorized to utilize the specified device and responsible for the delegation of the performance of the specified procedure;

(2) a statement of the activities, decision criteria, and plan the delegate shall follow when performing delegated procedures;

(3) selection criteria to screen patients for the appropriateness of non-ablative treatments;

(4) identification of devices and settings to be used for patients who meet selection criteria;

(5) methods by which the specified device is to be operated;

(6) a description of appropriate care and follow-up for common complications, serious injury, or emergencies as a result of the non-ablative treatment; and

(7) a statement of the activities, decision criteria, and plan the delegate shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made. Documentation shall be recorded within a reasonable time after each procedure, and may be performed on the patient's record or medical chart.

(h) Educational requirements for physicians and advanced health practitioners. Physicians and advanced health practitioners who are involved in the performance of non-ablative treatments must:

(1) complete basic training devoted to the principles of lasers, intense pulsed light devices and thermal, radiofrequency and other non-ablative devices, their instrumentation, physiological effects and safety requirements. For each device, the physician and advanced health practitioner must attend an initial training program. The initial training must last at least 24 hours, and include clinical applications of various wavelengths and hands-on practical sessions with each device and their appropriate surgical or therapeutic delivery systems; and

(2) Maintain competence to perform non-ablative procedures through documented hours of annual training regarding the appropriate standard of care in the field of non-ablative procedures and the use of specific device(s) operated.

(i) Educational requirements for delegates. A physician may delegate non-ablative procedures to a qualified delegate. The physician must ensure that the delegate complies with paragraphs (1) - (5) of this subsection prior to performing the non-ablative procedure in order to properly assess the delegate's competency.

(1) The delegate has completed and is able to document clinical and academic training in the subjects listed in subparagraphs (A) - (G) of this paragraph:

(A) fundamentals of laser operation;

(B) bioeffects of laser radiation on the eye and skin;

(C) significance of specular and diffuse reflections;

(D) non-beam hazards of lasers;

(E) non-ionizing radiation hazards;

(F) laser and laser system classifications; and

(G) control measures.

(2) The delegate has read and signed the facility's policies and procedures regarding the safe use of non-ablative devices.

(3) The delegate has received or participated in at least 16 hours of documented initial training in the field of non-ablative devices.

(4) The delegate has attended additional hours of documented training annually in the field of non-ablative procedures.

(5) The delegate has completed at least ten procedures of precepted training for each non-ablative procedure to assess competency.

(j) Quality assurance. The physician must ensure that there is a quality assurance program for the facility at which non-ablative procedures are performed in order for the purpose of continuously improving the selection and treatment of patients. An appropriate quality assurance program shall consist of the elements listed in paragraphs (1) - (5) of this subsection.

(1) A mechanism to identify complications and untoward effects of treatment and to determine their cause.

(2) A mechanism to review the adherence of delegates to standing delegation orders, standing medical orders and written protocols.

(3) A mechanism to monitor the quality of non-ablative treatments.

(4) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future standing delegation orders, standing medical orders, written protocols, and supervising responsibility.

(5) Ongoing training to improve the quality and performance of delegates.

(k) The deadline for compliance with the provisions of this section will be one year following the final adoption of this rule.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405303
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Effective date: September 12, 2004
Proposal publication date: July 2, 2004
For further information, please call: (512) 305-7016

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PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 283. LICENSING REQUIREMENTS FOR PHARMACISTS

22 TAC §283.9

The Texas State Board of Pharmacy adopts amendments to §283.9, concerning Fee Requirements for Licensure by Examination, Score Transfer and Reciprocity. The amendments are adopted without changes to the proposed text published in the June 25, 2004, issue of the *Texas Register* (29 TexReg 6032).

The adopted amendments increase the initial application fees for licensure by exam or score transfer, and for the initial application fee for licensure by reciprocity to include a surcharge required for funding Texas Online; and implement a recommendation by the Sunset Advisory Commission making all fees non-refundable.

No comments were received.

The amendments are adopted under §§551.002, 554.051, 558.051, and 558.101 of the Texas Pharmacy Act (Chapters 551-566 and 568-569 Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §558.051 and §558.101 as authorizing the agency to set application and licensure fees.

The statutes affected by this rule: Chapters 551-566 and 568-569, Texas Occupations Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 18, 2004.

TRD-200405214
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: September 7, 2004
Proposal publication date: June 25, 2004
For further information, please call: (512) 305-8028

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CHAPTER 291. PHARMACIES
SUBCHAPTER B. COMMUNITY PHARMACY (CLASS A)

22 TAC §291.34

The Texas State Board of Pharmacy adopts amendments to §291.34 concerning Records. The amendments are adopted with changes to the proposed text, as published in the June 25, 2004, issue of the *Texas Register* (29 TexReg 6033), based on comments received.

The adopted amendments ensure that prescriptions for controlled substances carried out by advance practice nurses and physician assistants contain the DEA number of the supervising practitioner, ensuring that the prescriptions are issued under the proper authority.

The agency received one comment from the Coalition for Nurses in Advanced Practice. It was suggested that the word "dangerous" be deleted from §291.34(b)(6)(C)(v) since physicians may now delegate prescriptions for non-Schedule II controlled substances and dangerous drugs. The board agrees with this comment and the word "dangerous" has been deleted from the rule.

The new rule is adopted under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551-566, and 568-569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this rule: Chapters 551-566 and 568-569, Texas Occupations Code.

§291.34. Records.

(a) Maintenance of records.

(1) Every inventory or other record required to be kept under the provisions of §291.31 of this title (relating to Definitions), §291.32 of this title (relating to Personnel), §291.33 of this title (relating to Operational Standards), §291.34 of this title (relating to Records), §291.35 of this title (relating to Triplicate Prescription Records), and §291.36 of this title (relating to Class A Pharmacies Dispensing Sterile Products) contained in Community Pharmacy (Class A) shall be kept by the pharmacy and be available, for at least two years from the date of such inventory or record, for inspecting and copying by the board or its representative and to other authorized local, state, or federal law enforcement agencies.

(2) Records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the pharmacy.

(3) Records of controlled substances, other than prescription drug orders, listed in Schedules III - V shall be maintained separately or readily retrievable from all other records of the pharmacy. For purposes of this subsection, readily retrievable means that the controlled substances shall be asterisked, red-lined, or in some other manner readily identifiable apart from all other items appearing on the record.

(4) Records, except when specifically required to be maintained in original or hard-copy form, may be maintained in an alternative data retention system, such as a data processing system or direct imaging system provided:

(A) the records maintained in the alternative system contain all of the information required on the manual record; and

(B) the data processing system is capable of producing a hard copy of the record upon the request of the board, its representative, or other authorized local, state, or federal law enforcement or regulatory agencies.

(b) Prescriptions.

(1) Professional responsibility.

(A) Pharmacists shall exercise sound professional judgment with respect to the accuracy and authenticity of any prescription drug order they dispense. If the pharmacist questions the accuracy or authenticity of a prescription drug order, he/she shall verify the order with the practitioner prior to dispensing.

(B) Prior to dispensing a prescription, pharmacists shall determine, in the exercise of sound professional judgment, that the prescription is a valid prescription. A pharmacist may not dispense a prescription drug if the pharmacist knows or should have known that the prescription was issued on the basis of an Internet-based or telephonic consultation without a valid patient-practitioner relationship.

(C) Subparagraph (B) of this paragraph does not prohibit a pharmacist from dispensing a prescription when a valid patient-practitioner relationship is not present in an emergency situation (e.g. a practitioner taking calls for the patient's regular practitioner).

(2) Written prescription drug orders.

(A) Practitioner's signature.

(i) Except as noted in clause (ii) of this subparagraph, written prescription drug orders shall be:

(I) manually signed by the practitioner; or

(II) electronically signed by the practitioner using a system which electronically replicates the practitioner's manual signature on the written prescription, provided:

(-a-) that security features of the system require the practitioner to authorize each use; and

(-b-) the prescription is printed on paper that is designed to prevent unauthorized copying of a completed prescription and to prevent the erasure or modification of information written on the prescription by the prescribing practitioner. (For example, the paper contains security provisions against copying that results in some indication on the copy that it is a copy and therefore render the prescription null and void.)

(ii) Prescription drug orders for Schedule II controlled substances shall be issued on an official prescription form as required by the Texas Controlled Substances Act, §481.075, and be manually signed by the practitioner.

(iii) A practitioner may sign a prescription drug order in the same manner as he would sign a check or legal document, e.g. J.H. Smith or John H. Smith.

(iv) Rubber stamped or otherwise reproduced signatures may not be used except as authorized in clause (i) of this subparagraph.

(v) The prescription drug order may not be signed by a practitioner's agent but may be prepared by an agent for the signature of a practitioner. However, the prescribing practitioner is responsible in case the prescription drug order does not conform in all essential respects to the law and regulations.

(B) Prescription drug orders written by practitioners in another state.

(i) Dangerous drug prescription orders. A pharmacist may dispense a prescription drug order for dangerous drugs issued by practitioners in a state other than Texas in the same manner as prescription drug orders for dangerous drugs issued by practitioners in Texas are dispensed.

(ii) Controlled substance prescription drug orders.

(I) A pharmacist may dispense prescription drug order for controlled substances in Schedule II issued by a practitioner in another state provided:

(-a-) the prescription is filled in compliance with a written plan approved by the Director of the Texas Department of Public Safety in consultation with the Board, which provides the manner in which the dispensing pharmacy may fill a prescription for a Schedule II controlled substance;

(-b-) the prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration (DEA) registration number, and who may legally prescribe Schedule II controlled substances in such other state; and

(-c-) the prescription drug order is not dispensed after the end of the seventh day after the date on which the prescription is issued.

(II) A pharmacist may dispense prescription drug orders for controlled substances in Schedule III, IV, or V issued by a practitioner in another state provided:

(-a-) the prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration (DEA) registration number, and who may legally prescribe Schedule III, IV, or V controlled substances in such other state;

(-b-) the prescription drug order is not dispensed or refilled more than six months from the initial date of issuance and may not be refilled more than five times; and

(-c-) if there are no refill instructions on the original written prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written prescription drug order have been dispensed, a new written prescription drug order is obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(C) Prescription drug orders written by practitioners in the United Mexican States or the Dominion of Canada.

(i) Controlled substance prescription drug orders. A pharmacist may not dispense a prescription drug order for a Schedule II, III, IV, or V controlled substance issued by a practitioner in the Dominion of Canada or the United Mexican States.

(ii) Dangerous drug prescription drug orders. A pharmacist may dispense a dangerous drug prescription issued by a person licensed in the Dominion of Canada or the United Mexican States as a physician, dentist, veterinarian, or podiatrist provided:

(I) the prescription drug order is an original written prescription; and

(II) if there are no refill instructions on the original written prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written prescription drug order have been dispensed, a new written prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of dangerous drugs.

(D) Prescription drug orders carried out or signed by an advanced practice nurse or physician assistant.

(i) A pharmacist may dispense a prescription drug order which is carried out or signed by an advanced practice nurse or physician assistant provided the advanced practice nurse or physician assistant is practicing in accordance with Subtitle B, Chapter 157, Occupations Code.

(ii) Each practitioner shall designate in writing the name of each advanced practice nurse or physician assistant authorized to carry out or sign a prescription drug order pursuant to Subtitle B, Chapter 157, Occupations Code. A list of the advanced practice nurses or physician assistants designated by the practitioner must be maintained in the practitioner's usual place of business. On request by a pharmacist, a practitioner shall furnish the pharmacist with a copy of the written authorization for a specific advanced practice nurse or physician assistant.

(E) Prescription drug orders for Schedule II controlled substances. No Schedule II controlled substance may be dispensed without a written prescription drug order of a practitioner on an official prescription form as required by the Texas Controlled Substances Act, §481.075.

(3) Verbal prescription drug orders.

(A) A verbal prescription drug order from a practitioner or a practitioner's designated agent may only be received by a pharmacist or a pharmacist-intern under the direct supervision of a pharmacist.

(B) A practitioner shall designate in writing the name of each agent authorized by the practitioner to communicate prescriptions verbally for the practitioner. The practitioner shall maintain at the practitioner's usual place of business a list of the designated agents. The practitioner shall provide a pharmacist with a copy of the practitioner's written authorization for a specific agent on the pharmacist's request.

(C) A pharmacist may not dispense a verbal prescription drug order for a Schedule III, IV, or V controlled substance issued by a practitioner licensed in another state unless the practitioner is also registered under the Texas Controlled Substances Act.

(D) A pharmacist may not dispense a verbal prescription drug order for a dangerous drug or a controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States unless the practitioner is also licensed in Texas.

(4) Electronic prescription drug orders. For the purpose of this subsection, prescription drug orders shall be considered the same as verbal prescription drug orders.

(A) An electronic prescription drug order may be transmitted by a practitioner or a practitioner's designated agent:

(i) directly to a pharmacy; or

(ii) through the use of a data communication device provided:

(I) the confidential prescription information is not altered during transmission; and

(II) confidential patient information is not accessed or maintained by the operator of the data communication device other than for legal purposes under federal and state law.

(B) A practitioner shall designate in writing the name of each agent authorized by the practitioner to electronically transmit prescriptions for the practitioner. The practitioner shall maintain at the practitioner's usual place of business a list of the designated agents. The practitioner shall provide a pharmacist with a copy of the practitioner's written authorization for a specific agent on the pharmacist's request.

(C) A pharmacist may not dispense an electronic prescription drug order for a:

(i) Schedule II controlled substance, except as authorized for faxed prescriptions in §481.074, Health and Safety Code;

(ii) Schedule III, IV, or V controlled substance issued by a practitioner licensed in another state unless the practitioner is also registered under the Texas Controlled Substances Act; or

(iii) dangerous drug or controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States unless the practitioner is also licensed in Texas.

(5) Original prescription drug order records.

(A) Original prescriptions shall be maintained by the pharmacy in numerical order and remain legible for a period of two years from the date of filling or the date of the last refill dispensed.

(B) If an original prescription drug order is changed, such prescription order shall be invalid and of no further force and effect; if additional drugs are to be dispensed, a new prescription drug order with a new and separate number is required.

(C) Original prescriptions shall be maintained in three separate files as follows:

(i) prescriptions for controlled substances listed in Schedule II;

(ii) prescriptions for controlled substances listed in Schedules III - V; and

(iii) prescriptions for dangerous drugs and nonprescription drugs.

(D) Original prescription records other than prescriptions for Schedule II controlled substances may be stored on microfilm, microfiche, or other system which is capable of producing a direct image of the original prescription record, e.g., digitalized imaging system. If original prescription records are stored in a direct imaging system, the following is applicable:

(i) the record of refills recorded on the original prescription must also be stored in this system;

(ii) the original prescription records must be maintained in numerical order and separated in three files as specified in subparagraph (C) of this paragraph; and

(iii) the pharmacy must provide immediate access to equipment necessary to render the records easily readable.

(6) Prescription drug order information.

(A) All original prescriptions shall bear:

(i) name of the patient, or if such drug is for an animal, the species of such animal and the name of the owner;

(ii) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as medication records;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(iv) name and strength of the drug prescribed;

(v) quantity prescribed;

(vi) directions for use;

(vii) intended use for the drug unless the practitioner determines the furnishing of this information is not in the best interest of the patient; and

(viii) date of issuance.

(B) All original electronic prescription drug orders shall bear:

(i) name of the patient, if such drug is for an animal, the species of such animal, and the name of the owner;

(ii) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as medication records;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(iv) name and strength of the drug prescribed;

(v) quantity prescribed;

(vi) directions for use;

(vii) indications for use, unless the practitioner determines the furnishing of this information is not in the best interest of the patient;

(viii) date of issuance;

(ix) a statement which indicates that the prescription has been electronically transmitted, (e.g., Faxed to or electronically transmitted to:);

(x) name, address, and electronic access number of the pharmacy to which the prescription was transmitted;

(xi) telephone number of the prescribing practitioner;

(xii) date the prescription drug order was electronically transmitted to the pharmacy, if different from the date of issuance of the prescription; and

(xiii) if transmitted by a designated agent, the full name of the designated agent.

(C) All original written prescriptions carried out or signed by an advanced practice nurse or physician assistant in accordance with Subtitle B, Chapter 157, Occupations Code, shall bear:

(i) name and address of the patient;

(ii) name, address, telephone number, and if the prescription is for a controlled substance, the DEA number of the supervising practitioner;

(iii) name, identification number, original signature and if the prescription is for a controlled substance, the DEA number of the advanced practice nurse or physician assistant;

(iv) address and telephone number of the clinic at which the prescription drug order was carried out or signed;

(v) name, strength, and quantity of the drug;

(vi) directions for use;

(vii) indications for use, if appropriate;

(viii) date of issuance; and

(ix) number of refills authorized.

(D) At the time of dispensing, a pharmacist is responsible for the addition of the following information to the original prescription:

(i) unique identification number of the prescription drug order;

(ii) initials or identification code of the dispensing pharmacist;

(iii) quantity dispensed, if different from the quantity prescribed;

(iv) date of dispensing, if different from the date of issuance; and

(v) brand name or manufacturer of the drug product actually dispensed, if the drug was prescribed by generic name or if a drug product other than the one prescribed was dispensed pursuant to the provisions of the Act, Chapters 562 and 563.

(7) Refills.

(A) Refills may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order.

(B) If there are no refill instructions on the original prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original prescription drug order have been dispensed, authorization from the prescribing practitioner shall be obtained prior to dispensing any refills.

(C) Refills of prescription drug orders for dangerous drugs or nonprescription drugs.

(i) Prescription drug orders for dangerous drugs or nonprescription drugs may not be refilled after one year from the date of issuance of the original prescription drug order.

(ii) If one year has expired from the date of issuance of an original prescription drug order for a dangerous drug or nonprescription drug, authorization shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of the drug.

(D) Refills of prescription drug orders for Schedules III - V controlled substances.

(i) Prescription drug orders for Schedules III - V controlled substances may not be refilled more than five times or after six months from the date of issuance of the original prescription drug order, whichever occurs first.

(ii) If a prescription drug order for a Schedule III, IV, or V controlled substance has been refilled a total of five times or if six months have expired from the date of issuance of the original prescription drug order, whichever occurs first, a new and separate prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(E) A pharmacist may exercise his professional judgment in refilling a prescription drug order for a drug, other than a controlled substance listed in Schedule II, without the authorization of the prescribing practitioner, provided:

(i) failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;

(ii) either:

(I) a natural or manmade disaster has occurred which prohibits the pharmacist from being able to contact the practitioner; or

(II) the pharmacist is unable to contact the practitioner after a reasonable effort;

(iii) the quantity of prescription drug dispensed does not exceed a 72-hour supply;

(iv) the pharmacist informs the patient or the patient's agent at the time of dispensing that the refill is being provided without such authorization and that authorization of the practitioner is required for future refills;

(v) the pharmacist informs the practitioner of the emergency refill at the earliest reasonable time;

(vi) the pharmacist maintains a record of the emergency refill containing the information required to be maintained on a prescription as specified in this subsection;

(vii) the pharmacist affixes a label to the dispensing container as specified in §291.33(c)(6) of this title; and

(viii) if the prescription was initially filled at another pharmacy, the pharmacist may exercise his professional judgment in refilling the prescription provided:

(I) the patient has the prescription container, label, receipt or other documentation from the other pharmacy which contains the essential information;

(II) after a reasonable effort, the pharmacist is unable to contact the other pharmacy to transfer the remaining prescription refills or there are no refills remaining on the prescription;

(III) the pharmacist, in his professional judgment, determines that such a request for an emergency refill is appropriate and meets the requirements of clauses (i) and (ii) of this subparagraph; and

(IV) the pharmacist complies with the requirements of clauses (iii) - (v) of this subparagraph.

(c) Patient medication records.

(1) A patient medication record system shall be maintained by the pharmacy for patients to whom prescription drug orders are dispensed.

(2) The patient medication record system shall provide for the immediate retrieval of information for the previous 12 months which is necessary for the dispensing pharmacist to conduct a prospective drug regimen review at the time a prescription drug order is presented for dispensing.

(3) The pharmacist-in-charge shall assure that a reasonable effort is made to obtain and record in the patient medication record at least the following information:

(A) full name of the patient for whom the drug is prescribed;

(B) address and telephone number of the patient;

(C) patient's age or date of birth;

(D) patient's gender;

(E) any known allergies, drug reactions, idiosyncrasies, and chronic conditions or disease states of the patient and the identity of any other drugs currently being used by the patient which may relate to prospective drug regimen review;

(F) pharmacist's comments relevant to the individual's drug therapy, including any other information unique to the specific patient or drug; and

(G) a list of all prescription drug orders dispensed (new and refill) to the patient by the pharmacy during the last two years. Such list shall contain the following information:

(i) date dispensed;

(ii) name, strength, and quantity of the drug dispensed;

(iii) prescribing practitioner's name;

(iv) unique identification number of the prescription; and

(v) name or initials of the dispensing pharmacists.

(4) A patient medication record shall be maintained in the pharmacy for two years. If patient medication records are maintained in a data processing system, all of the information specified in this subsection shall be maintained in a retrievable form for two years and information for the previous 12 months shall be maintained on-line.

(5) Nothing in this paragraph shall be construed as requiring a pharmacist to obtain, record, and maintain patient information other than prescription drug order information when a patient or patient's agent refuses to provide the necessary information for such patient medication records.

(d) Prescription drug order records maintained in a manual system.

(1) Original prescriptions shall be maintained in three files as specified in subsection (b)(5)(C) of this section.

(2) Refills.

(A) Each time a prescription drug order is refilled, a record of such refill shall be made:

(i) on the back of the prescription by recording the date of dispensing, the written initials or identification code of the dispensing pharmacist, and the amount dispensed. (If the pharmacist merely initials and dates the back of the prescription drug order, he or she shall be deemed to have dispensed a refill for the full face amount of the prescription drug order); or

(ii) on another appropriate, uniformly maintained, readily retrievable record, such as medication records, which indicates by patient name the following information:

(I) unique identification number of the prescription;

(II) name and strength of the drug dispensed;

(III) date of each dispensing;

(IV) quantity dispensed at each dispensing;

(V) initials or identification code of the dispensing pharmacist; and

(VI) total number of refills for the prescription.

(B) If refill records are maintained in accordance with subparagraph (A)(ii) of this paragraph, refill records for controlled substances in Schedules III - V shall be maintained separately from refill records of dangerous drugs and nonprescription drugs.

(3) Authorization of refills. Practitioner authorization for additional refills of a prescription drug order shall be noted on the original prescription, in addition to the documentation of dispensing the refill.

(4) Transfer of prescription drug order information. For the purpose of refill or initial dispensing, the transfer of original prescription drug order information is permissible between pharmacies, subject to the following requirements:

(A) the transfer of original prescription drug order information for controlled substances listed in Schedule III, IV, or V is permissible between pharmacies on a one-time basis;

(B) the transfer of original prescription drug order information for dangerous drugs is permissible between pharmacies without limitation up to the number of originally authorized refills;

(C) the transfer is communicated directly between pharmacists and/or pharmacist interns;

(D) both the original and the transferred prescription drug order are maintained for a period of two years from the date of last refill;

(E) the pharmacist or pharmacist intern transferring the prescription drug order information shall:

(i) write the word "void" on the face of the invalidated prescription drug order; and

(ii) record on the reverse of the invalidated prescription drug order the following information:

(I) the name, address, and if a controlled substance, the DEA registration number of the pharmacy to which such prescription drug order is transferred;

(II) the name of the pharmacist or pharmacist intern receiving the prescription drug order information;

(III) the name of the pharmacist or pharmacist intern transferring the prescription drug order information; and

(IV) the date of the transfer;

(F) the pharmacist or pharmacist intern receiving the transferred prescription drug order information shall:

(i) write the word "transfer" on the face of the transferred prescription drug order; and

(ii) record on the transferred prescription drug order the following information:

(I) original date of issuance and date of dispensing or receipt, if different from date of issuance;

(II) original prescription number and the number of refills authorized on the original prescription drug order;

(III) number of valid refills remaining and the date of last refill, if applicable;

(IV) name, address, and if a controlled substance, the DEA registration number of the pharmacy from which such prescription information is transferred; and

(V) name of the pharmacist or pharmacist intern transferring the prescription drug order information.

(5) A pharmacist or pharmacist intern may not refuse to transfer original prescription information to another pharmacist or pharmacist intern who is acting on behalf of a patient and who is making a request for this information as specified in paragraph (4) of this subsection.

(e) Prescription drug order records maintained in a data processing system.

(1) General requirements for records maintained in a data processing system.

(A) Compliance with data processing system requirements. If a Class A (community) pharmacy's data processing system is not in compliance with this subsection, the pharmacy must maintain a manual recordkeeping system as specified in subsection (c) of this section.

(B) Original prescriptions. Original prescriptions shall be maintained in three files as specified in subsection (b)(5)(C) of this section.

(C) Requirements for backup systems.

(i) The pharmacy shall maintain a backup copy of information stored in the data processing system using disk, tape, or other electronic backup system and update this backup copy on a regular basis, at least monthly, to assure that data is not lost due to system failure.

(ii) Data processing systems shall have a workable (electronic) data retention system which can produce an audit trail of

drug usage for the preceding two years as specified in paragraph (2)(G) of this subsection.

(D) Change or discontinuance of a data processing system.

(i) Records of dispensing. A pharmacy that changes or discontinues use of a data processing system must:

(I) transfer the records of dispensing to the new data processing system; or

(II) purge the records of dispensing to a printout which contains the same information required on the daily printout as specified in paragraph (2)(B) of this subsection. The information on this hard-copy printout shall be sorted and printed by prescription number and list each dispensing for this prescription chronologically.

(ii) Other records. A pharmacy that changes or discontinues use of a data processing system must:

(I) transfer the records to the new data processing system; or

(II) purge the records to a printout which contains all of the information required on the original document.

(iii) Maintenance of purged records. Information purged from a data processing system must be maintained by the pharmacy for two years from the date of initial entry into the data processing system.

(E) Loss of data. The pharmacist-in-charge shall report to the board in writing any significant loss of information from the data processing system within 10 days of discovery of the loss.

(2) Records of dispensing.

(A) Each time a prescription drug order is filled or refilled, a record of such dispensing shall be entered into the data processing system.

(B) The data processing system shall have the capacity to produce a daily hard-copy printout of all original prescriptions dispensed and refilled. This hard-copy printout shall contain the following information:

(i) unique identification number of the prescription;

(ii) date of dispensing;

(iii) patient name;

(iv) prescribing practitioner's name;

(v) name and strength of the drug product actually dispensed; if generic name, the brand name or manufacturer of drug dispensed;

(vi) quantity dispensed;

(vii) initials or an identification code of the dispensing pharmacist; and

(viii) if not immediately retrievable via CRT display, the following shall also be included on the hard-copy printout:

(I) patient's address;

(II) prescribing practitioner's address;

(III) practitioner's DEA registration number, if the prescription drug order is for a controlled substance;

(IV) quantity prescribed, if different from the quantity dispensed;

(V) date of issuance of the prescription drug order, if different from the date of dispensing; and

(VI) total number of refills dispensed to date for that prescription drug order.

(C) The daily hard-copy printout shall be produced within 72 hours of the date on which the prescription drug orders were dispensed and shall be maintained in a separate file at the pharmacy. Records of controlled substances shall be readily retrievable from records of noncontrolled substances.

(D) Each individual pharmacist who dispenses or refills a prescription drug order shall verify that the data indicated on the daily hard-copy printout is correct, by dating and signing such document in the same manner as signing a check or legal document (e.g., J.H. Smith, or John H. Smith) within seven days from the date of dispensing.

(E) In lieu of the printout described in subparagraph (B) of this paragraph, the pharmacy shall maintain a log book in which each individual pharmacist using the data processing system shall sign a statement each day, attesting to the fact that the information entered into the data processing system that day has been reviewed by him or her and is correct as entered. Such log book shall be maintained at the pharmacy employing such a system for a period of two years after the date of dispensing; provided, however, that the data processing system can produce the hard-copy printout on demand by an authorized agent of the Texas State Board of Pharmacy, the Texas Department of Public Safety, or the Drug Enforcement Administration. If no printer is available on site, the hard-copy printout shall be available within 48 hours with a certification by the individual providing the printout, which states that the printout is true and correct as of the date of entry and such information has not been altered, amended, or modified.

(F) The pharmacist-in-charge is responsible for the proper maintenance of such records and responsible that such data processing system can produce the records outlined in this section and that such system is in compliance with this subsection.

(G) The data processing system shall be capable of producing a hard-copy printout of an audit trail for all dispensings (original and refill) of any specified strength and dosage form of a drug (by either brand or generic name or both) during a specified time period.

(i) Such audit trail shall contain all of the information required on the daily printout as set out in subparagraph (B) of this paragraph.

(ii) The audit trail required in this subparagraph shall be supplied by the pharmacy within 48 hours, if requested by an authorized agent of the Texas State Board of Pharmacy, Department of Public Safety, or Drug Enforcement Administration.

(H) Failure to provide the records set out in this subsection, either on site or within 48 hours for whatever reason, constitutes prima facie evidence of failure to keep and maintain records.

(I) The data processing system shall provide on-line retrieval (via CRT display or hard-copy printout) of the information set out in subparagraph (B) of this paragraph of:

(i) the original controlled substance prescription drug orders currently authorized for refilling; and

(ii) the current refill history for Schedules III, IV, and V controlled substances for the immediately preceding six-month period.

(J) In the event that a pharmacy which uses a data processing system experiences system downtime, the following is applicable:

(i) an auxiliary procedure shall ensure that refills are authorized by the original prescription drug order and that the maximum number of refills has not been exceeded or authorization from the prescribing practitioner shall be obtained prior to dispensing a refill; and

(ii) all of the appropriate data shall be retained for on-line data entry as soon as the system is available for use again.

(3) Authorization of refills. Practitioner authorization for additional refills of a prescription drug order shall be noted as follows:

(A) on the hard-copy prescription drug order;

(B) on the daily hard-copy printout; or

(C) via the CRT display.

(4) Transfer of prescription drug order information. For the purpose of refill or initial dispensing, the transfer of original prescription drug order information is permissible between pharmacies, subject to the following requirements.

(A) The transfer of original prescription drug order information for controlled substances listed in Schedule III, IV, or V is permissible between pharmacies on a one-time basis only. However, pharmacies electronically sharing a real-time, on-line database may transfer up to the maximum refills permitted by law and the prescriber's authorization.

(B) The transfer of original prescription drug order information for dangerous drugs is permissible between pharmacies without limitation up to the number of originally authorized refills.

(C) The transfer is communicated directly between pharmacists and/or pharmacist interns or as authorized in paragraph (5) of this subsection.

(D) Both the original and the transferred prescription drug orders are maintained for a period of two years from the date of last refill.

(E) The pharmacist or pharmacist intern transferring the prescription drug order information shall:

(i) write the word "void" on the face of the invalidated prescription drug order; and

(ii) record on the reverse of the invalidated prescription drug order the following information:

(I) the name, address, and if a controlled substance, the DEA registration number of the pharmacy to which such prescription is transferred;

(II) the name of the pharmacist or pharmacist intern receiving the prescription drug order information;

(III) the name of the pharmacist or pharmacist intern transferring the prescription drug order information; and

(IV) the date of the transfer.

(F) The pharmacist or pharmacist intern receiving the transferred prescription drug order information shall:

(i) write the word "transfer" on the face of the transferred prescription drug order; and

(ii) record on the transferred prescription drug order the following information:

(I) original date of issuance and date of dispensing or receipt, if different from date of issuance;

(II) original prescription number and the number of refills authorized on the original prescription drug order;

(III) number of valid refills remaining and the date of last refill, if applicable;

(IV) name, address, and if a controlled substance, the DEA registration number of the pharmacy from which such prescription drug order information is transferred; and

(V) name of the pharmacist or pharmacist intern transferring the prescription drug order information.

(G) Prescription drug orders may not be transferred by non-electronic means during periods of downtime except on consultation with and authorization by a prescribing practitioner; provided however, during downtime, a hard copy of a prescription drug order may be made available for informational purposes only, to the patient, a pharmacist or pharmacist intern, and the prescription may be read to a pharmacist or pharmacist intern by telephone.

(H) The original prescription drug order shall be invalidated in the data processing system for purposes of filling or refilling, but shall be maintained in the data processing system for refill history purposes.

(I) If the data processing system has the capacity to store all the information required in subparagraphs (E) and (F) of this paragraph, the pharmacist is not required to record this information on the original or transferred prescription drug order.

(J) The data processing system shall have a mechanism to prohibit the transfer or refilling of controlled substance prescription drug orders which have been previously transferred.

(5) Electronic transfer of prescription drug order information between pharmacies. Pharmacies electronically accessing the same prescription drug order records may electronically transfer prescription information if the following requirements are met.

(A) The original prescription is voided and the following information is documented in the records of the transferring pharmacy:

(i) the name, address, and if a controlled substance, the DEA registration number of the pharmacy to which such prescription is transferred;

(ii) the name of the pharmacist or pharmacist intern receiving the prescription drug order information; and

(iii) the date of the transfer.

(B) Pharmacies not owned by the same person may electronically access the same prescription drug order records, provided the owner or chief executive officer of each pharmacy signs an agreement allowing access to such prescription drug order records.

(6) A pharmacist or pharmacist intern may not refuse to transfer original prescription information to another pharmacist or pharmacist intern who is acting on behalf of a patient and who is making a request for this information as specified in paragraphs (4) and (5) of this subsection.

(f) Limitation to one type of recordkeeping system. When filing prescription drug order information a pharmacy may use only one of the two systems described in subsection (d) or (e) of this section.

(g) Distribution of controlled substances to another registrant. A pharmacy may distribute controlled substances to a practitioner, another pharmacy, or other registrant, without being registered to distribute, under the following conditions.

(1) The registrant to whom the controlled substance is to be distributed is registered under the Controlled Substances Act to dispense that controlled substance.

(2) The total number of dosage units of controlled substances distributed by a pharmacy may not exceed 5.0% of all controlled substances dispensed and distributed by the pharmacy during the 12-month period in which the pharmacy is registered; if at any time it does exceed 5.0%, the pharmacy is required to obtain an additional registration to distribute controlled substances.

(3) If the distribution is for a Schedule III, IV, or V controlled substance, a record shall be maintained which indicates:

(A) the actual date of distribution;

(B) the name, strength, and quantity of controlled substances distributed;

(C) the name, address, and DEA registration number of the distributing pharmacy; and

(D) the name, address, and DEA registration number of the pharmacy, practitioner, or other registrant to whom the controlled substances are distributed.

(4) If the distribution is for a Schedule I or II controlled substance, the following is applicable.

(A) The pharmacy, practitioner, or other registrant who is receiving the controlled substances shall issue Copy 1 and Copy 2 of a DEA order form (DEA 222C) to the distributing pharmacy.

(B) The distributing pharmacy shall:

(i) complete the area on the DEA order form (DEA 222C) titled "To Be Filled in by Supplier";

(ii) maintain Copy 1 of the DEA order form (DEA 222C) at the pharmacy for two years; and

(iii) forward Copy 2 of the DEA order form (DEA 222C) to the Divisional Office of the Drug Enforcement Administration.

(h) Other records. Other records to be maintained by a pharmacy:

(1) a permanent log of the initials or identification codes which will identify each dispensing pharmacist by name (the initials or identification code shall be unique to ensure that each pharmacist can be identified, i.e., identical initials or identification codes shall not be used);

(2) Copy 3 of DEA order form (DEA 222C) which has been properly dated, initialed, and filed, and all copies of each unaccepted or defective order form and any attached statements or other documents;

(3) a hard copy of the power of attorney to sign DEA 222C order forms (if applicable);

(4) suppliers' invoices of dangerous drugs and controlled substances; a pharmacist shall verify that the controlled drugs listed on the invoices were actually received by clearly recording his/her initials and the actual date of receipt of the controlled substances;

(5) suppliers' credit memos for controlled substances and dangerous drugs;

(6) a hard copy of inventories required by §291.17 of this title (relating to Inventory Requirements);

(7) hard-copy reports of surrender or destruction of controlled substances and/or dangerous drugs to an appropriate state or federal agency;

(8) a hard copy of the Schedule V nonprescription register book;

(9) records of distribution of controlled substances and/or dangerous drugs to other pharmacies, practitioners, or registrants; and

(10) a hard copy of any notification required by the Texas Pharmacy Act or the sections in this chapter, including, but not limited to, the following:

(A) reports of theft or significant loss of controlled substances to DEA, Department of Public Safety, and the board;

(B) notifications of a change in pharmacist-in-charge of a pharmacy; and

(C) reports of a fire or other disaster which may affect the strength, purity, or labeling of drugs, medications, devices, or other materials used in the diagnosis or treatment of injury, illness, and disease.

(i) Permission to maintain central records. Any pharmacy that uses a centralized recordkeeping system for invoices and financial data shall comply with the following procedures.

(1) Controlled substance records. Invoices and financial data for controlled substances may be maintained at a central location provided the following conditions are met.

(A) Prior to the initiation of central recordkeeping, the pharmacy submits written notification by registered or certified mail to the divisional director of the Drug Enforcement Administration as required by Title 21, Code of Federal Regulations, §1304.04(a), and submits a copy of this written notification to the Texas State Board of Pharmacy. Unless the registrant is informed by the divisional director of the Drug Enforcement Administration that permission to keep central records is denied, the pharmacy may maintain central records commencing 14 days after receipt of notification by the divisional director.

(B) The pharmacy maintains a copy of the notification required in subparagraph (A) of this paragraph.

(C) The records to be maintained at the central record location shall not include executed DEA order forms, prescription drug orders, or controlled substance inventories, which shall be maintained at the pharmacy.

(2) Dangerous drug records. Invoices and financial data for dangerous drugs may be maintained at a central location.

(3) Access to records. If the records are kept on microfilm, computer media, or in any form requiring special equipment to render the records easily readable, the pharmacy shall provide access to such equipment with the records.

(4) Delivery of records. The pharmacy agrees to deliver all or any part of such records to the pharmacy location within two business days of written request of a board agent or any other authorized official.

(j) Ownership of pharmacy records. For the purposes of these sections, a pharmacy licensed under the Act is the only entity which may legally own and maintain prescription drug records.

(k) Confidentiality.

(1) A pharmacist shall provide adequate security of prescription drug orders, and patient medication records to prevent indiscriminate or unauthorized access to confidential health information.

If prescription drug orders, requests for refill authorization, or other confidential health information are not transmitted directly between a pharmacy and a physician but are transmitted through a data communication device, confidential health information may not be accessed or maintained by the operator of the data communication device unless specifically authorized to obtain the confidential information by this subsection.

(2) Confidential records are privileged and may be released only to:

(A) the patient or the patient's agent;

(B) a practitioner or another pharmacist if, in the pharmacist's professional judgement, the release is necessary to protect the patient's health and well being;

(C) the board or to a person or another state or federal agency authorized by law to receive the confidential record;

(D) a law enforcement agency engaged in investigation of a suspected violation of Chapter 481 or 483, Health and Safety Code, or the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Section 801 et seq.);

(E) a person employed by a state agency that licenses a practitioner, if the person is performing the person's official duties; or

(F) an insurance carrier or other third party payor authorized by a patient to receive such information.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 18, 2004.

TRD-200405215
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: September 7, 2004
Proposal publication date: June 25, 2004
For further information, please call: (512) 305-8028

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CHAPTER 297. PHARMACY TECHNICIANS

22 TAC §297.7

The Texas State Board of Pharmacy adopts amendments to §297.7 concerning Exemption from Pharmacy Technician Certification Requirements. The amendments are adopted without changes to the proposed text published in the June 25, 2004, issue of the *Texas Register* (29 TexReg 6034).

The adopted amendment clarifies the status of long-term exempt pharmacy technicians and clarify the status of rural county exempt pharmacy technicians whose exemption is cancelled.

No comments were received.

The amendment is adopted under §§551.002, 554.002(6), 554.051, and 568.002, Occupations Code. The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.002(6) as authorizing the agency to regulate the training, qualifications, and employment of a pharmacy technician. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §568.002 as authorizing the agency to establish a system for the registration of pharmacy technicians including the issuance and renewal of registrations and to exempt pharmacy technicians from the certification requirement under conditions.

The statutes affected by this rule: Chapters 551-566 and 568-569, Texas Occupations Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 18, 2004.

TRD-200405216
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: September 7, 2004
Proposal publication date: June 25, 2004
For further information, please call: (512) 305-8028

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PART 25. STRUCTURAL PEST CONTROL BOARD

CHAPTER 593. LICENSES

22 TAC §593.7

The Texas Structural Pest Control Board adopts 22 TAC §593.7 concerning fees with no changes published in the June 11, 2004 issue of the *Texas Register* (29 TexReg 5711.)

Justification for the rule is that the proposal will add an additional $5.00 cost to all new licenses issued by the Board. The new fee cost will be used to cover the costs of Texas Online.

The rule will function in that all new licenses issued by the Board will be paying the costs of Texas Online.

No comments were received.

No group or association made comments for or against the rule.

The amendment is adopted under the Structural Pest Control Act, Chapter 1951 of the Occupations Code, which provides the Texas Structural Pest Control Board with the authority to license and regulate the structural pest control industry.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 16, 2004.

TRD-200405184
Dale Burnett
Executive Director
Structural Pest Control Board
Effective date: September 5, 2004
Proposal publication date: June 11, 2004
For further information, please call: (512) 305-8270

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PART 33. TEXAS STATE BOARD OF EXAMINERS OF PERFUSIONISTS

CHAPTER 761. PERFUSIONISTS

22 TAC §§761.2, 761.3, 761.12, 761.13, 761.15, 761.17, 761.19 - 761.21

The Texas State Board of Examiners of Perfusionists (board) adopts amendments to §§761.2, 761.3, 761.12, 761.13, 761.15, 761.17, and 761.19 and new §761.20 and §761.21, concerning the licensure of and regulation of perfusionists. The amendments to §§761.2, 761.3 and 761.13 are adopted with changes to the proposed text as published in the March 5, 2004, issue of the *Texas Register* (29 TexReg 2178). The amendments to §§761.12, 761.15, 761.17, 761.19, and new §761.20 and §761.21 are adopted without changes, and will not be republished.

Specifically, the amendments cover language on policy against discrimination; fees; clarification on student loan default; update continuing education requirements to follow the American Board of Cardiovascular Perfusion; administrative penalties for a violation; delete the word "settlement" in an informal disposition; and amend language regarding non-payment of child support. New §761.20 and §761.21 cover relevant factors and severity level and sanction guide.

The amendments are necessary to implement House Bill 2985, 78th Legislature, 2003, which added Occupations Code, Chapter 101, Subchapter G, which established the Office of Patient Protection, relating to fees; Senate Bill 1152, 78th Legislature, 2003, which amends Government Code, Chapter 2054, to require participation in Texas Online; Senate Bill 161, 78th Legislature, 2003, which amends Occupations Code, Chapter 603, relating to emergency suspensions and administrative penalties. The licensing fee amendments are required as a result of revisions to the Health and Safety Code, §12.0111 and §12.0112, pursuant to House Bill 2292, 78th Legislature, 2003.

No comments were received during the public comment period. However, the board is making the following changes due to staff comments.

Change: Concerning §761.2(r)(3), the word "will" was corrected to the word "is" for proper grammar.

Change: Concerning §761.3(a)(1)(O), the word "commnity" was replaced with the word "community" for correction of misspelling.

Change: Concerning §761.13(b)(3)(E), second sentence, the words "initiated anD/or" were replaced with the words "initiating and/or" for clarity.

The new sections and amendments are adopted under Texas Occupations Code, Chapter 603, which provides the Texas State Board of Examiners of Perfusionists with the authority to adopt rules concerning the regulation of perfusion that are reasonably necessary to properly perform its duties under this Act.

§761.2. The Board's Organization and Administration.

(a) Officers.

(1) Chairman.

(A) The chairman shall preside at all board meetings at which he or she is in attendance and perform all duties prescribed by law or board rules.

(B) The chairman shall serve as an ex-officio member of all committees except the complaint committee.

(2) Vice-chairman.

(A) The vice-chairman shall perform the duties of the chairman in case of the absence or disability of the chairman.

(B) In case the office of chairman becomes vacant, the vice-chairman shall serve until a successor is elected.

(b) Meetings.

(1) The board shall hold at least two regular meetings and additional meetings as necessary during each year, at such designated date, place, and time as may be determined by the chairman.

(2) Special meetings may be called by the chairman at such times, dates, and places as become necessary for the transaction of board business.

(3) Meetings shall be announced and conducted under the provisions of the Texas Open Meetings Act, Texas Government Code, Chapter 551.

(c) Quorum. A quorum of the board necessary to conduct official business is five members.

(d) Transaction of official business.

(1) The board may transact official business only when in a legally constituted meeting with a quorum present.

(2) The board shall not be bound in any way by any statement or action on the part of any board or staff member except when a statement or action is in pursuance of specific instructions of the board.

(3) Board action shall require a majority vote of those members present and voting.

(e) Policy against discrimination. The board shall make no decision in the discharge of its statutory authority with regard to any person's race, creed, gender, religion, national origin, geographical distribution, age, physical condition, economic status, sexual orientation, or genetic information.

(f) Conflict of Interest. Any board member who has a conflict of interest regarding any matter before the board, such as a matter pertaining to an applicant's eligibility for licensure or a complaint against or a violation by a licensee, shall so declare this to the board and shall not participate in any board proceedings involving that individual or matter.

(g) Attendance.

(1) The policy of the board is that members shall attend regular and committee meetings as scheduled.

(2) The board may report to the governor and the Texas Sunset Advisory Commission the attendance records of members.

(3) Except in case of emergency, board members shall notify the executive secretary at least 48 hours prior to the scheduled meeting if unable to be present.

(4) Except in case of emergency, the executive secretary shall notify the chairman at least 48 hours prior to the scheduled meeting if unable to be present.

(h) Reimbursement for expense.

(1) A board member is entitled to a per diem payment at the rate set by the General Appropriations Act for each day that the member engages in the business of the board.

(2) A board member is entitled to compensation for travel expenses as provided by the General Appropriations Act.

(3) Payment to board members of per diem and travel expenses shall be requested on official state travel vouchers which have been approved by the executive secretary.

(4) Board-approved requests for board staff for out-of-state travel for board activities shall be pre-approved.

(5) Attendance at conventions, meetings, and seminars must be clearly related to the performance of board duties and show a benefit to the state.

(i) Rules of order. The latest edition of Roberts Rules of Order shall be the basis of parliamentary decisions except where otherwise provided by these board rules.

(j) Agendas.

(1) The executive secretary shall prepare and submit to each member of the board, prior to each meeting, an agenda which includes items requested by members, items required by law, unfinished business, and other matters of board business which have been approved for discussion by the chairman.

(2) The official agenda of a meeting shall be filed with the Texas Secretary of State in accordance with the Texas Open Meetings Act, Texas Government Code, Chapter 551.

(k) Minutes.

(1) Drafts of the minutes of each meeting shall be forwarded to each member of the board for review and comments prior to approval by the board.

(2) After approval by the board, the minutes of any board meeting are official only when affixed with the original signatures of the chairman and the executive secretary and official seal of the board.

(3) The official minutes of board meetings shall be kept in the office of the executive secretary and shall be available to any person desiring to examine them during regular office hours.

(l) Official records.

(1) All official records of the board including application materials, except files containing information considered confidential under the provisions of the Texas Open Records Act, Texas Government Code, Chapter 552 shall be open for inspection during regular office hours.

(2) Official records may not be taken from board offices; however, persons may obtain photocopies of files upon written request and by paying the cost per page set by the department. Payment shall be made prior to release of the records.

(m) Elections.

(1) At the meeting held nearest to February 1 of each odd-numbered year, the board shall elect by a majority vote of those members present and voting, a chairman and a vice-chairman.

(2) A vacancy which occurs in the offices of chairman or vice-chairman shall be filled, for the duration of the unexpired term, by a majority vote of those members present and voting at the next board meeting.

(3) A board member shall not serve more than two consecutive terms in the office of chairman or vice chairman.

(n) Committees.

(1) The board or the chairman with the approval of the board may establish committees deemed necessary to assist the board in carrying out its duties and responsibilities.

(2) The chairman may appoint the members of the board to serve on committees and may designate the committee chairman.

(3) The chairman of the board may appoint nonboard members to serve as committee members on a consultant or voluntary basis, subject to board approval.

(4) Committee chairmen shall make regular reports to the board in interim written reports or at regular meetings, as needed.

(5) Committees shall direct all reports or other materials to the executive secretary for distribution.

(6) Committees shall meet when called by the chairman of the committee or when so directed by the board.

(7) The following standing committees shall be appointed by the newly elected chairman each odd-numbered year to serve a term of two years.

(A) The rules committee shall be composed of at least two board members who are licensed perfusionists and one public member of the board. The committee shall review all board rules at least once annually to ensure that the rules are current in relation to perfusionist practice, and may recommend and propose adoption of rules to the board. The committee shall consider all petitions for adoption of rules and shall recommend disposition of these petitions to the board in accordance with subsection(s) of this section.

(B) The complaint committee shall be composed of one board member who is a licensed perfusionist and one public member of the board. The committee may review complaints received by the board and shall recommend action to be taken on complaints in accordance with §761.15 of this title (relating to Violations, Complaints, Investigations, and Procedures).

(o) Official seal. The official seal of the board shall consist of two concentric circles with the words "Texas State Board of Examiners of Perfusionists" circularly arranged about the inner edge of the outermost circle, and in the center of the innermost circle there shall be a five-pointed star, surrounded by the live oak and olive branches common to official state seals.

(p) Registry.

(1) Each year the executive secretary shall publish a registry of current licensees.

(2) The registry shall include, but not be limited to, the name of current licensees.

(3) An original copy of the registry will be available for inspection by licensees and members of the public in the office of the executive secretary. Upon receipt of a written request and payment of a fee, the executive secretary shall furnish at cost a copy to a licensee or member of the public. The cost of a copy of the registry or any portion thereof shall be in accordance with the cost guidelines of the department.

(q) Consumer information. The executive secretary with the approval of the board shall publish information of consumer interest which describes the regulatory functions of the board, board procedures to handle and resolve consumer complaints, and the profession of perfusion.

(r) Fees.

(1) The board has established reasonable and necessary fees to provide the funds to support the activities listed in paragraph (4) of this subsection and other activities required by the Act.

(2) For all applications and renewal applications, the board will authorized to collect subscription and convenience fees, in amounts determined by the Texas Online Authority, to recover costs associated with application and renewal application processing through Texas Online.

(3) For all applications and renewal applications, the board is authorized to collect fees to fund the Office of Patient Protection, Health Professions Council, as mandated by law.

(4) Schedule of fees for licensure as a perfusionist and a provisional licensed perfusionist is as follows:

(A) application and initial license fees--$175;

(B) license fee for upgrade of provisional licensed perfusionist--$75;

(C) a license issued for a one-year term--$175;

(D) a license issued for a two-year term--$350;

(E) late renewal fee--$100;

(F) license certificate and identification card replacement fee--$10;

(G) child support reinstatement fee--$40;

(H) student loan default reinstatement fee--$40; and

(I) verification fee--$10 per licensee.

(5) An applicant whose check for the application fee is not honored by the financial institution may reinstate the application by remitting to the board a money order or check for guaranteed funds within 30 days of the date of receipt of the board's notice. An application will be considered incomplete until the fee has been received and cleared through the appropriate financial institution.

(6) A licensee whose check for the renewal fee is not honored by the financial institution may remit to the board a money order or check for guaranteed funds within 30 days of the date of receipt of the board's notice. Otherwise, the license shall not be renewed. If a renewal card has already been issued, it shall be subject to revocation.

(7) Fees paid to the board by applicants are not refundable.

(8) Any remittance submitted to the board in payment of a required fee must be in the form of a personal check, certified check, or money order.

(9) The board shall make periodic reviews of its fee schedule and make any adjustments necessary to provide funds to meet its expenses without creating an unnecessary surplus. Such adjustments shall be through rule amendments.

(s) Petition for adoption of a rule.

(1) Purpose. The rule's purpose is to delineate the board's procedures for the submission, consideration, and disposition of a petition to the board to adopt a rule.

(2) Submission of the petition.

(A) Any person may petition the board to adopt a rule.

(B) The petition shall be in writing, shall contain the petitioner's name and address, and shall describe the rule and the reason for it; however, if the executive secretary determines that further information is necessary to assist the board in reaching a decision, the executive secretary may require that the petitioner resubmit the petition and that it contain:

(i) a brief explanation of the proposed rule;

(ii) the text of the proposed rule prepared in a manner to indicate the words to be added or deleted from the current text, if any;

(iii) a statement of the statutory or other authority under which the rule is to be promulgated; and

(iv) the public benefits anticipated as a result of adopting the rule or the anticipated injury or inequity which would result from the failure to adopt the proposed rule.

(C) The board may deny a petition which does not contain the information in subparagraph (B) of this paragraph if the executive secretary determines that it is necessary.

(D) The petition shall be mailed or delivered to the executive secretary, Texas State Board of Examiners of Perfusionists, 1100 West 49th Street, Austin, Texas 78756-3183.

(3) Consideration and disposition of the petition.

(A) The executive secretary shall submit a completed petition to the board for its consideration.

(B) Within 60 days after receipt of the petition by the executive secretary, or within 60 days after receipt of a resubmitted petition in accordance with paragraph (2)(B)(i) - (iv) of this subsection, the board shall either:

(i) deny the petition; or

(ii) initiate rule-making procedures by referring the petition to the rules committee for its recommendation. The committee shall report its recommendations to the board at its next regular meeting.

(C) The board may deny parts of the petition or institute rule making procedures on parts of the petition.

(D) If the board denies the petition, the executive secretary shall give the petitioner written notice of the board's action, including the reason(s).

(E) Final determination of the wording of the new rules made in accordance with the Administrative Procedure Act shall be at the discretion of the board.

(4) Subsequent petitions to adopt the same or similar rules. All initial petitions for the adoption of a rule shall be presented to and decided by the board in accordance with the provisions of paragraphs (2) and (3) of this subsection. The board may refuse to consider any subsequent petition for the adoption of the same or similar rule submitted within six months after the date of the initial petition.

§761.3. Professional and Ethical Conduct.

(a) Code of ethics. These rules shall constitute a code of ethics as authorized by the Act, §603.151(6).

(1) Professional representation and responsibilities.

(A) A licensee shall not misrepresent his or her professional qualifications or credentials.

(B) A licensee shall not make any false or misleading claims pertaining to the indications and efficacy of the practice of perfusion.

(C) A licensee shall not permit the use of his or her name for the purpose of certifying that perfusion services have been rendered unless that licensee has provided those services.

(D) A licensee shall not promote or endorse products in a manner that is false or misleading.

(E) A licensee shall disclose to the reimbursing entity any personal gain or profit from any supply, procedure or service.

(F) A licensee shall have the responsibility of reporting alleged misrepresentations or violations of board rules to the board's executive secretary.

(G) A licensee shall comply with any order relating to the licensee which is issued by the board.

(H) A licensee shall not aid or abet the practice or misrepresentation of an unlicensed person when that person is required to have a license under the Act.

(I) A licensee shall not make any false, misleading, or deceptive claims in any advertisement, announcement, or presentation relating to the services of the licensee.

(J) A licensee shall not interfere with an investigation or disciplinary proceeding by willful misrepresentation of facts to the board or its authorized representative or by the use of threats or harassment against any person associated with investigation or disciplinary proceedings.

(K) The licensee who willfully misstates fact during the application, examination, or recertification processes is guilty of unethical conduct. Likewise the willful misstatement of fact regarding the title or membership in a professional community is considered unethical conduct.

(L) The licensee who consciously fails to promote both the safety and protection of the public is guilty of unethical conduct.

(M) The licensee who willfully disregards the patient for monetary gain is guilty of unethical conduct. Examples of such conduct are unjustified reimbursement for services performed or prejudicial compensation.

(N) The licensee who shows willful disregard for sound patient care by acts of omission is guilty of unethical conduct.

(O) A licensee shall subscribe to all other applicable ethical standards of the medical community.

(P) The licensee accepts the responsibility for subscribing to the preceding Code of Ethics and for reporting unethical professional conduct.

(Q) A licensee shall supervise a provisional licensed perfusionist in accordance with §761.9 of this title (relating to Provisional Licensed Perfusionist).

(2) Professional relationships.

(A) A licensee shall make known to a prospective reimbursing entity the important aspects of the professional relationship including fees and arrangements for payment which might affect the reimbursing entity's decision to enter into the relationship.

(B) A licensee shall bill a reimbursing entity in the manner agreed to by the licensee and entity in accordance with 42 United States Code §1395nn, relating to the anti-kickback statute and the Health and Safety Code, §161.091, relating to illegal renumeration.

(C) A licensee shall not receive or give a commission or rebate or any other form of renumeration for the referral of professional services.

(D) A licensee shall disclose to the reimbursing entity any interest in commercial enterprises relating to the practice of perfusion which the licensee promotes for the purpose of personal gain or profit.

(E) A licensee shall practice perfusion without discrimination based on race, creed, gender, religion, national origin, age, sexual orientation, or genetic information.

(F) A licensee shall not violate any provision of any federal or state statute relating to confidentiality of patient communications and records.

(G) A licensee shall not engage in sexual contact with a patient. The term "sexual contact" means any type of sexual behavior described in the Texas Penal Code, Chapters 21, 22 or 43 and includes sexual intercourse.

(3) Billing information required; prohibited practices.

(A) On the written request of a patient, a patient's guardian, a patient's parent if the patient is a minor, or the billing entity, a licensee shall provide, in plain language, a written explanation of the charges for acts of perfusion previously made on a bill or statement for the patient. This requirement applies even if the charges are to be paid by a third party.

(B) A licensee may not overcharge or overtreat a patient.

(4) Sanctions. A licensee shall be subject to disciplinary action by the board if under the Crime Victims Compensation Act, Texas Code of Criminal Procedure, Article 56.31, the licensee is issued a public letter of reprimand, is assessed a civil penalty by a court, or has an administrative penalty imposed by the attorney general's office.

(b) Disclosure. A licensee shall make a reasonable attempt to notify each patient of the name, mailing address, and telephone number of the board for the purpose of directing complaints to the board by providing notification:

(1) on each written contract for services of a licensee; or

(2) on a sign prominently displayed in the primary place of business of each licensee; or

(3) in a bill for service provided by a licensee to a patient or reimbursing entity.

(c) Unlawful false, misleading, or deceptive advertising. A licensee shall not use advertising that is false, misleading, or deceptive or that is not readily subject to verification. False, misleading, or deceptive advertising or advertising that is not really subject to verification includes advertising that:

(1) makes a material misrepresentation of fact or omits a fact necessary to make the statement as a whole not materially misleading;

(2) makes a representation likely to create an unjustified expectation about the results of a health care service or procedure;

(3) compares a health care professional's services with another health care professional's services unless the comparison can be factually substantiated;

(4) contains a testimonial;

(5) causes confusion or misunderstanding as to the credentials, education, or licensure of a perfusionist;

(6) advertises or represents that health care insurance deductibles or copayments may be waived or are not applicable to health care services to be provided if the deductibles or copayments are required;

(7) advertises or represents that the benefits of a health benefit plan will be accepted as full payment when deductibles or copayments are required;

(8) makes a representation that is designed to take advantage of the fears or emotions of a particularly susceptible type of patient; or

(9) advertises or represents, in the use of a professional name, a title or professional identification that is expressly or commonly reserved to or used by another profession or professional.

§761.13. Minimum Continuing Education Requirements.

(a) Completion of continuing education (CE) requirements with current certification by the American Board of Cardiovascular Perfusion (ABCP) or its successor agency. Completion of continuing education requirements shall be documented by demonstrating current certification by the ABCP annual license renewal.

(b) Completion of CE requirements without current certification by the ABCP. Licensed perfusionists without current certification by the ABCP at the time of license renewal must meet the following criteria.

(1) Document a minimum of 45 continuing education credit (CEUs) in a three-year period by submitting the professional activity report on the approved form every third year. A minimum of 15 hours of CEU must be earned in Category I. The activity period covered in the professional activity report is from the date of licensure to the third licensure renewal date and every subsequent third license renewal date.

(2) Document a minimum of 40 clinical perfusions in a one-year period by submitting the clinical activity report on the approved form upon annual license renewal. The first clinical activity report from a newly licensed perfusionist is due on the second license renewal date.

(3) One CEU or contact hour activity is defined as 50 minutes spent in an organized, structured or unstructured learning experience. Categories of CEU activities are:

(A) Category I--Perfusion Meetings and Other Perfusion Related Activity--Perfusion meetings are those programs and seminars in which a minimum of 75% of the contact hours consist of perfusion related material. Only those meetings approved by the ABCP will qualify for Category 1 hours. Examples:

(i) International, national regional, and state perfusion meetings.

(ii) Publication of perfusion related book chapter or paper in a professional journal.

(iii) Presentation at an international, national, regional or state perfusion journal.

(B) Category II--Non-Accredited Perfusion Meetings and Other Medical Meetings- This category includes international, national, regional, and state meetings that have not been approved by the ABCP, local perfusion meetings and all other medically related meetings. Examples:

(i) International, National, Regional, and State, perfusion meetings that have not been accredited by the ABCP.

(ii) Local perfusion meetings (do not require ABCP accreditation). Any perfusion meeting NOT EQUALLY ACCESSIBLE to the general CCP community, this includes manufacturer-specific and company-sponsored educational activities.

(iii) International, National, Regional, or Local medically-related meetings.

(C) Category III- Individual Education and Other Self-Study Activities Credit in this category is acquired on an hour for hour basis of the time spent in these non-accredited or non-supervised activities. Examples:

(i) Reading or viewing medical journals, audio-visual, or other educational material.

(ii) Participation in electronic forums.

(iii) Participation in a Journal Club.

(iv) Participation in degree-oriented, professional-related course work.

(v) Presentation of perfusion topic at a non-perfusion meeting.

(D) A minimum of 40 clinical perfusions per year are required of every licensed perfusionist. A maximum of 15 activities may be documented as intraoperative pump standbys.

(E) 40 cases are required each year as the Primary Perfusionist for Cardiopulmonary bypass, ECMO, VAD, Isolated Limb Perfusion, or VENO-VENO bypass, or documented intraoperative pump standby. For each ECMO or VAD case, one case credit will be awarded for initiating and/or managing an eight-hour shift.

(4) Documentation of activities. Licensed perfusionists are responsible for providing documentation of their professional activities. This documentation must be submitted along with the professional activity report. Credit will not be granted for activities that are not documented. The suitable documentation is outlined as follows:

(A) Category I--Perfusion meetings--Approved perfusion meetings held before June 30, 1998, may be documented by copies of registration receipts or official meeting name tags. For approved perfusion meetings held after June 30, 1998, an official document from the meeting sponsor documenting attendance and the number of hours received must be provided.

(i) Perfusion Publications must have complete reference of book or article (authors, title, journal and date/volume of journal.

(ii) Perfusion Presentations must have copy of program agenda.

(B) Category II--International, national, regional, and state perfusion meetings not accredited by the ABCP, local perfusion meetings and all other medical meetings--must provide an official document stating CEUs awarded and copy of the meeting program.

(C) Category III--All self-study activities will require an official record of completion or written summary of the activity.

(c) Exceptions. Any deviation from the continuing education requirements will be reviewed on a case-by-case basis by the Board. A request for special consideration shall be submitted in writing a minimum of 60 days prior to expiration of the license.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405297
Debra Sue Douglas
Chairman
Texas State Board of Examiners of Perfusionists
Effective date: September 12, 2004
Proposal publication date: March 5, 2004
For further information, please call: (512) 458-7236

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PART 36. COUNCIL ON SEX OFFENDER TREATMENT

CHAPTER 810. COUNCIL ON SEX OFFENDER TREATMENT

The Council on Sex Offender Treatment (Council) adopts the repeal of §§810.1 - 810.9, 810.31 - 810.34, 810.61 - 810.64, 810.91, 810.92, 810.121, 810.122, 810.151 - 810.153, 810.181 - 810.183, 810.211, 810.241, 810.242, 810.271 and 810.272; and new §§810.1 - 810.9, 810.31, 810.34, 810.61 - 810.67, 810.91, 810.92, 810.121, 810.122, 810.151 - 810.153, 810.181 - 810.183, 810.211, 810.241, 810.242, and 810.271 - 810.275, concerning the registration of sex offender treatment providers and the civil commitment of sexually violent predators. New §§810.2 - 810.5, 810.7 - 810.9, 810.32 - 810.34, 810.61 - 810.67, 810.91, 810.92, 810.121, 810.122, 810.152, 810.153, 810.181, 810.182, 810.211, 810.242, and 810.275 are adopted with changes to the proposed rule text as published in the June 4, 2004, issue of the *Texas Register* (29 TexReg 5502). The repeal of §§810.1 - 810.9, 810.31 - 810.34, 810.61 - 810.64, 810.91 - 810.92, 810.121, 810.122, 810.151 - 810.153, 810.181 - 810.183, 810.211, 810.241, 810.242, 810.271, and 810.272; and new §§810.1, 810.6, 810.31, 810.151, 810.183, 810.241, and 810.271 - 810.274 are adopted without changes and will not be published.

Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 810.1 - 810.9, 810.31 - 810.34, 810.61 - 810.64, 810.91, 810.92, 810.121, 810.122, 810.151 - 810.153, 810.181 - 810.183, 810.211, 810.241, 810.242, 810.271, and 810.272 were reviewed and the council determined that the reasons for adopting the sections continue to exist in that rules concerning the registration of sex offender treatment providers and the civil commitment of sexually violent predators are still needed; however, the rules are repealed and adopted as new rules as described in this preamble. The adopted repeals and new sections are the result of the comprehensive rule review undertaken by the council and the council's staff.

In general, each section was reviewed in order to ensure appropriate subchapter, section, and paragraph organization; to ensure clarity; to improve spelling, grammar, and punctuation; to ensure that the rules reflect current legal and policy considerations; to ensure accuracy of legal citations; to delete repetitive, obsolete, or unnecessary language; to improve draftsmanship; and to make the rules more accessible, understandable, and usable.

The following changes are adopted relating to the repeal and adoption of Subchapter A (Sex Offender Treatment Provider Registry.) Regarding §810.1(c), the rule is adopted to provide a statement of the council's history.

Regarding §810.2, new definitions of ATSA, biennium, client, custodian, guardian, juvenile court, reportable conviction or adjudication, valid court order, ability to give consent, accountability, anti-androgens, aversive conditioning, clarification, containment approach, denial, deviant sexual arousal, deviant sexual behavior, dynamic risk factors, empathy, grooming, HIPAA, juvenile with sexual behavior problems, offense cycle, offense specific, static risk factors, successful completion of treatment are adopted. These terms were not previously defined, but the definitions are necessary in order to clarify the adopted new chapter.

Regarding §810.2, the definitions of Act, case management, council, fiscal year, registry, polygraph examination, polygraph examiner, penile plethysmograph, and rehabilitation service are amended in order to correct legal citations, reflect current knowledge of the practice of sex offender treatment, improve draftsmanship, and clarify ambiguous definitions. Regarding §810.2, the definition of department was deleted as unnecessary.

Regarding §810.3, the rule is adopted to clarify the experience of registrants in the database maintained by the council.

Regarding §810.4, the rules relating to registration renewal are adopted to clarify the continuing education and renewal processes, in accordance with the two-year licensing provisions of House Bill 2292, 78th Regular Session.

Regarding §810.4, the rules relating to fees are adopted to clarify the licensing fee structure in accordance with the two-year licensing provisions of House Bill 2292, 78th Regular Session. New §810.5(7) - (8) are adopted to assess and collect fees associated with Texas Online services and the Office of Patient Protection, in accordance with Senate Bill 1152, 78th Regular Session, and House Bill 2985, 78th Regular Session.

Regarding §810.8(a)(1) - (4), new rules are adopted to set out the criteria the council will use in evaluating criminal convictions for registration purposes.

The following changes are adopted relating to the repeal and adoption of Subchapter B (Criminal Background Check). Section 810.33 is adopted to correct a punctuation error.

The following changes are adopted relating to the repeal and adoption of Subchapter C (Standards of Practice.) Regarding §810.61, the section is adopted to clarify the introductory statements relating to standards of practice.

Regarding §810.62(a), the rules are adopted to require sex offender treatment providers to be aware of professional and legal obligations; to not make statements that a client is no longer at any risk to reoffend; to refuse referrals for re-evaluations in certain circumstances; to recognize there are no tools to prove or disprove if a client has committed a specific sexual crime; and to facilitate follow-up services.

Regarding §810.62(b), the rules are adopted to clarify that community safety is the greatest consideration for sex offender treatment providers; to clarify what a containment model is; to distinguish between adults and juveniles; to require that treatment

plans be completed within 30 days and reassessed at least annually; to require that behavior contracts include provisions to avert high-risk situations and must be reassessed periodically; to clarify how a provider defines progress in treatment; to communicate certain information to the supervising officer; to require registrant notification to the appropriate authority when a client leaves treatment; to clarify the extent to which the degree of denial is taken into consideration in entering treatment and identifying treatment needs; to clarify the limitations and strengths of the penile plethysmograph; to clarify which polygraph examiners may be utilized and to clarify the use of polygraphs in treatment; to clarify decisions regarding contact between clients and children; and to require registrants to assist in the selection and education of potential chaperones for contacts between clients and children. Rules relating to juveniles with sexual behavior problems and clients who are developmentally delayed are moved to the appropriate section.

Regarding §810.63, language is adopted to distinguish between adult and juvenile clients. Information relating to juveniles with sexual behavior problems is moved to the appropriate section.

Regarding §810.63(c), the rule is adopted to clearly define the evaluation procedures.

Regarding §810.63(d), the rule is adopted to clarify the information gathered during the evaluation process.

Regarding §810.64, the section is adopted to provide for a section designated to this topic; to bring together related rules from other sections; and to propose new rules relating to the treatment of juveniles with sexual behavior problems.

Regarding §810.65, the section is adopted to provide for a section designated to this topic and to propose new rules relating to the treatment of adult female sex offenders.

Regarding §810.66, the section is adopted to provide for a section designated to this topic; to bring together related rules from other sections; and to adopt new rules relating to the treatment of developmentally delayed clients.

Regarding §810.67, the section is adopted to clarify treatment components generally accepted as most important to the effective treatment of sexual deviancy.

The following changes are adopted relating to the repeal and adoption of Subchapter D (Code of Professional Ethics.) Regarding §810.92(b)(3), the rule is adopted to provide additional examples of dual relationships. Regarding §810.92(c), the rule is adopted to require registrant compliance with the Health Insurance Portability and Accountability Act and Texas Health and Safety Code, Chapter 611 (relating to Mental Health Records).

The following changes are adopted relating to the repeal and adoption of Subchapter E (General Provisions.) Regarding §810.121(c), the rule is adopted to incorporate statutory language concerning the civil commitment program.

Regarding §810.122, new definitions of child safety zone; Global Positioning Satellite Tracking; Interagency Case Management Team; residential facility; and supervision, treatment, and GPS requirements are adopted. Definitions of Act, biennial examination expert, civil commitment, civil commitment case manager, civil commitment treatment provider, multidisciplinary team, penile plethysmograph, clinical polygraph examination, polygraph examiner, repeat sexual offender, and sexually violent predator are adopted in order to correct legal citations, reflect current knowledge, improve draftsmanship, and clarify ambiguous definitions. Definitions of board, department, sexual arousal and preference assessment, supervised housing, supervision contract and tracking services are adopted for deletion as unnecessary.

The following changes are adopted relating to the repeal and adoption of Subchapter F (Civil Commitment.) Regarding §810.151, the rule is adopted to clarify the role of the Council on Sex Offender Treatment in the administration of the Act.

Regarding §810.152, the rule is adopted to clarify that a case manager shall be approved by the council and shall be provided with all documentation relating to the client.

Regarding §810.153, the section is adopted to reflect current knowledge of outpatient treatment and supervision programs.

The following changes are adopted relating to the repeal and adoption of Subchapter G (Civil Commitment Case Manager and Treatment Provider Duties and Responsibilities.) Regarding §810.181, the section is adopted to clarify the purpose of the subchapter.

Regarding §810.182, the section is adopted to reflect current knowledge and procedures associated with case manager duties.

Regarding §810.183, the section is adopted to reflect current knowledge and procedures associated with treatment provider duties.

The following changes are adopted relating to the repeal and adoption of Subchapter H (Civil Commitment Review). Regarding §810.211, the section is adopted to update requirements relating to the content and timeliness of the biennial examination.

The following changes are adopted relating to the repeal and adoption of Subchapter I (Petition for Release). Regarding §§810.241 and 810.242, the sections are adopted to reflect current procedures regarding petition for release.

The following changes are adopted relating to the repeal and adoption of Subchapter J (Miscellaneous Provisions). Regarding §810.271, the section is adopted to reflect statutory language relating to the release and exchange of information.

Regarding §§810.272, 810.273, and 810.275, the sections are adopted comply with the requirements of Senate Bill 871, 78th Regular Session, relating to the release and exchange of information.

Regarding §810.274, the section is adopted to reflect statutory language relating to criminal penalty.

Additionally, the review resulted in minor editorial changes throughout the rules which are necessary to improve or correct punctuation, verb tense, subject and verb agreement, sentence structure, non-substantive word choice, and other grammatical and structural matters.

The council published a Notice of Intention to Review the sections in the *Texas Register* on April 30, 2004. The council received no comments on these sections as a result of the publication of the notice.

The following comment was received concerning the proposed repeal and new sections. Following each comment is the council's response and any resulting change(s).

Comment: One commenter supported the inclusion of the plethysmograph in the assessment of juveniles and recommended adding to the juvenile evaluation the use of the Hare Psychopathy Youth Version. The commenter also recommended the inclusion of the victim's therapist in §810.64(a)(5), relating to the multidisciplinary approach and containment model for working with juveniles. The commenter questioned whether "consent" is the appropriate verb in §810.64(b)(6). The commenter recommended that special needs groups, as referred to in §810.66(c)(2)(M), should be allowed to go up to 90 minutes.

Response: The council agrees and modified §810.64(e)(3) to include the Hare Psychopathy Youth Version. Section 810.64(a)(5) is modified to include the victim's therapist. The council reviewed §810.64(b)(6) and determined that use of the verb "consent" is appropriate. The council agrees that special needs groups can go up to 90 minutes and modified §810.66(c)(2)(M) accordingly.

One individual provided comments on the rules. The commenter was generally in favor of the proposal, but asked questions and made recommendations.

The council reviewed the following staff comments.

Concerning §§810.2 - 810.5, 810.7 - 810.9, 810.32 - 810.34, 810.61 - 810.67, 810.91 - 810.92, 810.121 - 810.122, 810.152 - 810.153, 810.181 - 810.182, 810.211, 810.242, and 810.275, the sections were revised for punctuation, grammar, legal citations, and clarity.

Regarding §810.64(a)(12), the rule was modified to cite examples of risk management strategies.

Regarding §810.64(b)(2)(B) and §810.64(b)(2)(E), the rules were modified to clarify the evaluation of juveniles with sexual behavior problems.

Regarding §810.64(j)(4), the rule is added to ensure that supervised visits do not impede juvenile's progress in treatment.

Regarding §810.65(12), the rule is modified to require that female sex offenders shall be assessed for deviant sexual interest/arousal to ensure public safety.

Regarding §810.65(20), the rule is added to require evaluations of female sex offenders to comply with the evaluation rules relating to adult sex offenders or juveniles with sexual behavior problems.

Regarding §810.92(d)(5), the rule is modified to allow for the use of other appropriate evaluation instruments in addition to the Phallometric.

SUBCHAPTER A. SEX OFFENDER TREATMENT PROVIDER REGISTRY

22 TAC §§810.1 - 810.9

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405275
Walter J. Meyers, M.D.
Chairperson
Council on Sex Offender Treatment
Effective date: September 12, 2004
Proposal publication date: June 4, 2004
For further information, please call: (512) 458-7236

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22 TAC §§810.1 - 810.9

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.2. Definitions.

(a) General Definitions.

(1) ATSA--Association for the Treatment of Sexual Abusers.

(2) Act--Texas Occupations Code, Chapter 110, relating to the Council on Sex Offender Treatment.

(3) Biennium--Every two years.

(4) Case Management--The coordination and implementation of activities directed toward supervising, treating, and managing the adult sex offender or juvenile with sexual behavioral problems.

(5) Client(s)--Used interchangeably with adult sex offenders and juveniles with sexual behavior problems.

(6) Council--Means the Council on Sex Offender Treatment. The council consists of 7 members, appointed by the Governor with the advice and consent of the senate.

(7) Custodian--The adult who is responsible for the adult or child.

(8) Fiscal year--September 1 through August 31.

(9) Guardian--The person who, under court order, is the guardian of the person of the adult or the child or the public or private agency with whom the adult or juvenile has been placed by a court.

(10) HIPAA--Health Insurance Portability and Accountability Act, Title 45, Code of Federal Regulations (CFR), Parts 160 and 164.

(11) Juvenile Court--A court designated under the Family Code, Title 3, Juvenile Justice Code, §51.04, to exercise jurisdiction over the proceedings.

(12) Reportable Conviction or Adjudication--A conviction or adjudication, regardless of the pendency of an appeal.

(13) Registered Sex Offender Treatment Provider--A treatment provider listed in the council's registry and who is recognized based on training and experience to provide assessment and treatment to adult sex offenders and juveniles with sexual behavioral problems.

(14) Registrant--A person who is listed in the registry.

(15) Registry--A database maintained by the council that contains the names of persons who have met the council's criteria in the treatment of sex offenders and who provide mental health or medical services for the treatment of sex offenders.

(16) Valid Court Order--A court order entered under Title 3, Juvenile Justice Code, §54.04, concerning a child adjudicated to have engaged in conduct indicating a need for supervision.

(b) Treatment Definitions.

(1) Ability to Give Consent--Consent is an expressed agreement. Consent cannot be given by someone who is not of the legal age, is emotionally or cognitively disabled, or under the influence of drugs or alcohol. The legal age to give consent in the State of Texas is 17 years old.

(2) Accountability--Accurate attributions of responsibility, without distortion, minimization, or denial.

(3) Anti-androgens--Medication used to reduce the endogenous levels of testosterone and can reduce the sex drive and may help to control deviant sexual arousal.

(4) Aversive Conditioning--Behavioral techniques that involve pairing deviant sexual arousal with a noxious stimulus in order to reduce deviant sexual arousal.

(5) Clarification--The process designed for the primary benefit of the victim, by which the adult sex offender or juvenile with sexual behavior problems clarifies that the responsibility for the assault/abuse resides with the adult offender or juvenile. The victim has no responsibility for the adult offender or juvenile's behavior. It addresses the harm done to the victim and the family. The victim's participation is never required and is sometimes contraindicated. All contact is victim centered and based on the victim's need.

(6) Containment Approach--A method of case management and treatment that seeks to hold adult sex offenders and juveniles with sexual behavioral problems accountable through the combined use of both internal and external control measures. A containment approach requires the integration of a collection of attitudes, expectations, laws, policies, procedures, and practices.

(7) Denial-Refusal to acknowledge in whole or part sexually deviant arousal, sexually deviant intent, and/or sexually deviant behavior.

(8) Deviant Sexual Arousal--A pattern of physiological sexual responses to inappropriate fantasies, thoughts, objects, and/or persons that may or may not precede a sexual act. Deviant sexual arousal is the most obvious manifestation of deviant sexual interests.

(9) Deviant Sexual Behavior--A sexual act that meets one or more of the subsequent criteria:

(A) is with a person under the legal age of consent (17 years of age);

(B) is with a person who is unable to give consent;

(C) is forced, causes physical harm, is coerced, uses intimidation or deceit, or is paid for; or

(D) is harmful or degrading.

(10) Dynamic Risk Factors--Risk factors that can change over time and are therefore important targets for treatment and supervision. Dynamic risk factors include but are not limited to associations with antisocial peers, deviant sexual fantasies, and substance use.

(11) Empathy--The ability to identify and understand another person's feelings, situation, or ideas.

(12) Grooming--The process of desensitizing and manipulating the victim(s) and/or others for the purpose of gaining an opportunity to commit a sexually deviant act.

(13) Juvenile with Sexual Behavior Problems--A person who is 10 years of age or older and under 17 years of age who commits any sexual interaction with a person of any age against the victim's will, without knowing consent, or in an aggressive, exploitative, or threatening manner (Juvenile Justice Code Title 3, §51.02).

(14) Offense Cycle--The specific sequence(s) of thoughts, feelings, behaviors, and events that precede a sexual offense. The offense cycle is thought to be a precursor to sexual offending and should be addressed in relapse prevention.

(15) Offense Specific--Consistent with current professional practices, and means a long-term comprehensive set of planned therapeutic experiences and interventions to modify sexually abusive thoughts and behaviors. Such treatment specifically addresses the occurrence and dynamics of sexually deviant behavior and utilizes specific strategies to promote change and reduce the chance of re-offending. Sex offense specific programming focuses on concrete details of the actual sexual behavior, the fantasies, the arousal, the planning, the denial, and the rationalizations. The primary treatment modality is cognitive behavioral group therapy.

(16) Polygraph (Clinical) Examination--The employment of any instrumentation complying with the required minimum standards of the Texas Polygraph Examiner's Act and used for the purpose of measuring the physiological changes associated with deception. Four types of polygraphs used in the management of adult sex offenders and juveniles with sexual behavior problems are the disclosure polygraph, sexual history polygraph, maintenance polygraph, and the monitoring polygraph.

(17) Polygraph Examiner--A licensed person who shall adhere to the standards set forth by the Joint Polygraph Committee on Offender Testing (JPCOT).

(18) Penile Plethysmograph--A diagnostic method to assess sexual arousal by measuring the blood flow (tumescence) to the penis during the presentation of sexual stimuli in a laboratory setting.

(19) Rehabilitation Service--A mental health treatment or medical intervention program designed to treat or remedy a client's mental or medical problem that may relate or contribute to the client's criminal or paraphilic problem.

(20) Sex Offender--A person who:

(A) is convicted of committing or adjudicated to have committed a sex crime under the laws of a state or under federal law, including a conviction of a sex crime under the uniform code of military justice;

(B) is awarded deferred adjudication for a sex crime under the laws of a state or under federal law;

(C) admits to having violated the law of a state or federal law with regard to sexual conduct; or

(D) experiences or evidences a paraphiliac disorder as defined by the current version of the Diagnostic and Statistical Manual (DSM), as published by the American Psychiatric Association Press, including any subsequent revision of the manual, which may place a person at risk for the violation of sex offender laws.

(21) Static Risk Factors--Risk factors that are unlikely to change over time such as number of prior offenses, diagnosis of psychopathy or diagnosis of paraphilia.

(22) Successful Completion of Treatment--Includes but is not limited to admitting and accepting responsibility for all crimes,

demonstrating the ability to control deviant sexual arousal, understanding of current and instant offense cycle, increase in pro-social behaviors, increase in support systems, improved social competency, compliance with supervision, compliance with court conditions, increase understanding of victimization, no deception indicated on maintenance and monitoring polygraphs, completing and passing the sex history polygraph, approved safety plans and relapse prevention plans, successful completion of adjunct treatments (for example: anger management, substance abuse, etc.), and the integration and practical application of the program goals. The Registered Sex Offender Treatment Provider determines successful completion of treatment.

§810.3. Registry Criteria.

The council maintains a database of registrants whose experience in the treatment of adult sex offenders and juveniles with sexual behavior problems may vary. The council shall recognize the experience and training of treatment providers in either one of two categories. These may be "Registered Sex Offender Treatment Provider" or "Affiliate Sex Offender Treatment Provider."

(1) Registered Sex Offender Treatment Provider (RSOTP). The council may waive any prerequisite to registration for an application after receiving the applicant's credentials and determining that the applicant holds a valid registration from another state that has registration requirements substantially equivalent to those of this state. To be eligible as a RSOTP, the applicant must first meet all of the following criteria:

(A) licensed or certified to practice as a physician, psychiatrist, psychologist, licensed professional counselor, licensed marriage and family therapist, licensed master social worker-advanced clinical practitioner, or advanced nurse practitioner recognized as a psychiatric clinical nurse specialist or psychiatric mental health nurse practitioner, and who provides mental health or medical services for the treatment of sex offenders. The license status must be current and active;

(B) experience and training required as listed in clauses (i)-(ii) of this subparagraph:

(i) possess a minimum of 1000 hours of clinical experience in the areas of assessment and treatment of sex offenders, obtained within a consecutive seven-year period, and provide two reference letters from licensed or certified professionals who have actual knowledge of the applicant's clinical work in sex offender treatment; and

(ii) possess a minimum of 40 hours of documented continuing education training, as defined in §810.7 of this title (relating to Documentation of Experience and Training), obtained within three years prior to application date, in the specific area of sex offender assessment and treatment. Of the initial 40 hours training required, 30 hours must be in sex offender specific training. Ten hours must be in sexual assault issues and/or sexual assault survivor related training;

(C) submit a complete and accurate description of their treatment program on a form provided by the council;

(D) persons making initial application or renewing their eligibility for the registry shall adhere to Subchapter C. Standards of Practice and Subchapter D. Code of Professional Ethics and shall comply with the following:

(i) not have been convicted of any felony, or of any misdemeanor involving a sex offense, nor have received deferred adjudication for a sex offense, unless sufficient evidence of rehabilitation has been established as determined by the council;

(ii) not have had licensure revoked, canceled, suspended, or placed on probationary status by any professional licensing body, unless sufficient evidence of rehabilitation has been established as determined by the council;

(iii) not have been determined by any professional licensing body to have engaged in unprofessional or unethical conduct, unless sufficient evidence of rehabilitation has been established as determined by the council;

(iv) not have been determined by the council to have engaged in deceit or fraud in connection with the delivery of services or documentation of registry requirements or registry eligibility;

(v) submit themselves to a criminal history background check. An applicant shall be required to submit a complete set of fingerprints with the application documents, or other information necessary to conduct a criminal history background check to be submitted to the Texas Department of Public Safety or to another law enforcement agency. If fingerprints are requested, the fingerprints must be taken by a peace officer or a person authorized by the council and must be placed on a form prescribed by the Texas Department of Public Safety; and

(vi) not have violated any rule adopted by the council;

(E) submit an application fee defined in §810.5 of this title (relating to Fees);

(F) submit a copy of his or her professional license, as set out in subparagraph (A) of this paragraph, indicating the applicant is current and in good standing;

(G) sign the application form(s) and attest to the accuracy of the application before a notary public; and

(H) complete the process within 90 days of the application's receipt in the council office.

(2) Affiliate Sex Offender Treatment Provider (ASOTP). To be eligible as an ASOTP, the applicant must meet all of the following criteria:

(A) licensed or certified to practice as a physician, psychiatrist, psychologist, psychological associate, licensed professional counselor, licensed marriage and family therapist, licensed master social worker, advanced nurse practitioner, licensed marriage and family therapist associate, licensed professional counselor intern, provisionally licensed psychologist, recognized as a psychiatric clinical nurse specialist or psychiatric mental health nurse practitioner, who provides mental health or medical services for the rehabilitation of sex offenders;

(B) experience and training required as listed in clauses (i) - (iii) of this subparagraph:

(i) possess a minimum of 250 documented and verified hours of clinical experience in the areas of assessment and treatment of sex offenders, provide two reference letters from licensed or certified professionals who have actual knowledge of the applicant's clinical work in sex offender treatment;

(ii) supervised by an RSOTP in accordance with paragraph (4)(C) of this subsection until RSOTP status is reached; and

(iii) possess a minimum of 40 hours of documented continuing education training, as defined in §810.7 of this title, obtained within three years prior to application date, in the specific area of sex offender assessment and treatment. Of the initial 40 hours training required, 30 hours must be in sex offender specific training. Ten

hours must be in sexual assault issues and/or sexual assault survivor related training;

(C) complete and submit an accurate description of their treatment program on a form provided by the council;

(D) persons making initial application or renewing their eligibility for the registry shall adhere to Subchapter C. Standards and Subchapter D. Code of Professional Ethics shall comply with the following:

(i) not have been convicted of any felony, or of any misdemeanor involving a sex offense, nor have received deferred adjudication for a sex offense, unless sufficient evidence of rehabilitation has been established as determined by the council;

(ii) not have had licensure revoked, canceled, suspended, or placed on probationary status by any professional licensing body, unless sufficient evidence of rehabilitation has been established as determined by the council;

(iii) not have been determined by any professional licensing body to have engaged in unprofessional or unethical conduct, unless sufficient evidence of rehabilitation has been established as determined by the council;

(iv) not have been determined by the council to have engaged in deceit or fraud in connection with the delivery of services or documentation of registry requirements of registry eligibility;

(v) submit themselves to a criminal history background check. An applicant may be required to submit a complete set of fingerprints with the application documents, or other information necessary to conduct a criminal history background check to be submitted to the Texas Department of Public Safety or to another law enforcement agency. If fingerprints are requested, the fingerprints must be taken by a peace officer or a person authorized by the council and must be placed on a form prescribed by the Texas Department of Public Safety; and

(vi) not have violated any rule adopted by the council;

(E) submit an application fee defined in §810.5 of this title;

(F) submit a copy of his or her professional license or certification as set out in subparagraph (A) of this paragraph, indicating the applicant is current and in good standing;

(G) sign the application form(s) and attest to the accuracy of the application in the presence of a notary public; and

(H) complete the process within 90 days of the application's receipt in the council office.

(3) Specialized Competencies. Registered Sex Offender Treatment Providers with specialized competencies in the assessment and treatment of juvenile, female, and/or developmentally delayed sex offenders may have those competencies listed by their name in the Registry, if they meet the following criteria (certification is required only for the initial publication and not thereafter):

(A) possess at least 250 hours experience in the assessment and treatment of juvenile, female, or developmentally delayed sex offenders; these hours may be part of the original training and experience hours required for the original certification (going back up to 7 years);

(B) possess a minimum of 24 hours of documented continuing education training in the assessment and treatment of juvenile, female, or developmentally delayed sex offenders; these hours may be part of the original training and experience hours required for the original certification (going back up to 7 years); and

(C) pay an annual or biennial fee for each specialty as defined in §810.5 of this title.

(4) Supervision. All ASOTP's providing any sex offender treatment must be supervised. Supervision will include the following.

(A) An ASOTP providing any sex offender treatment is required to be under the supervision of an approved RSOTP supervisor. The ASOTP must provide a notarized copy of supervision documentation annually, to the council during the renewal period.

(B) An RSOTP supervisor that has not been a supervisor prior to the effective date of this rule must meet the following criteria:

(i) five years experience as a RSOTP and one of the following:

(I) designated as a supervisor under their license title;

(II) designated as a licensed psychologist or physician; or

(III) designated as a faculty member or adjunct faculty member in an accredited clinical training program of their discipline; and

(ii) designation as an approved RSOTP supervisor, which will require an annual credentialing fee as defined in §810.5 of this title.

(C) The ASOTP must receive face-to-face supervision at least one hour per month, or if providing more than 20 hours of direct clinical sex offender assessment and treatment per month, the ASOTP must receive one hour of supervision per every 20 hours of sex offender assessment and treatment.

(D) The supervising RSOTP must submit annual documentation to the council at the time of their renewal; the documentation will contain the name(s) of the ASOTP(s) that have been supervised during the year. The supervising RSOTP will be required to use a form provided by the council.

(5) Registration Certificates. Upon successful completion of the application or renewal process, registrants will receive an official certificate from the council. This certificate must be displayed at all locations where sex offender treatment is provided and or provide a copy on initial intake. For a nominal fee, duplicate certificates may be obtained for this purpose.

(A) The Council on Sex Offender Treatment Providers (council) shall prepare and provide to each registrant a certificate, which contains the registrant's name and certificate number.

(B) A registrant shall not display a registration certificate, which has been reproduced or is expired, suspended, or revoked.

(C) Any certificate issued by the council remains the property of the council and must be surrendered to the council upon demand.

(D) The address and telephone number of the council must be displayed at all locations where sex offender treatment is conducted and/or provide a copy on initial intake for the purpose of directing complaints against the registrant to the council.

(6) Application processing. The council shall comply with the following procedures in processing applications for a license.

(A) The following times shall apply from a completed application receipt and acceptance date for filing or until the date a written notice is issued stating the application is deficient and additional specific information is required. A written notice of application approval may be sent instead of the notice of acceptance of a complete application. The times are as follows:

(i) letter of acceptance of application for registry renewal - 30 days; and

(ii) letter of initial application deficiency - 30 days.

(B) The following times shall apply from the receipt of the last item necessary to complete the application until the date of issuance of written notice approving or denying the application. The times for denial include notification of the proposed decision and of the opportunity, if required, to show compliance with the law and of the opportunity for a formal hearing. The times are as follows:

(i) approval of application- 42 days; and

(ii) letter of denial of license or registration-90 days.

(7) Refund processing. The council shall comply with the following procedures in processing refunds of fees paid to the council. In the event an application is not processed in the times stated in paragraph (6)(A) of this subsection.

(A) The applicant has the right to request reimbursement of all fees paid in that particular application process. Application for reimbursement shall be made to the executive director. If the executive director does not agree that the time has been violated or finds that good cause existed for exceeding the time, the request will be denied.

(B) Good cause for exceeding the time is considered to exist if the number of applications for registration or renewal exceeds by 15% or more, the applications processed in the same calendar quarter of the preceding year; another public or private entity relied upon by the council in the application process caused the delay; or any other condition exists giving the council good cause for exceeding the time.

(C) If the executive director denies a request for reimbursement under subparagraph (A) of this paragraph the applicant may appeal to the council for a timely resolution of any dispute arising from a violation of the times. The applicant shall give written notice to the council at the address of the council that he or she requests full reimbursement of all fees paid because his or her application was not processed within the applicable time. The executive director shall submit a written report of the facts related to the processing of the application and of any good cause for exceeding the applicable time. The council shall provide written notice of the decision to the applicant and the executive director. The council shall decide an appeal in favor of the applicant, if the applicable time was exceeded and good cause was not established. If the council decides the appeal in favor of the applicant, full reimbursement of all fees paid in that particular application process shall be made.

(D) The times for contested cases related to the denial of registration or renewal are not included with the times listed in paragraphs (6)(A) and (6)(B) of this subsection. The time for conducting a contested case hearing runs from the date the council receives a written hearing request until the council's decision is final and appealable. A hearing may be completed within three to nine months, but may be shorter or longer depending on the particular circumstances of the hearing, the workload of the department and the scheduling of council meetings.

§810.4. Registry Renewal.

In order to maintain eligibility for the registry, the primary license of each renewal must be current and active. All renewal applicants must comply with the following:

(1) Number of continuing education hours. All renewal applicants shall include by the end of every fiscal year, a minimum of 12 hours of continuing education documentation in sex offender treatment of which 3 hours may be in sexual assault victim related training, beginning September 1999. All biennial renewals shall include by the end of the two year cycle, a minimum of 24 hours of continuing education documentation in sex offender treatment of which 6 hours may be in sexual assault victim related training, beginning September 2005.

(2) Renewal forms. All renewal applicants shall submit renewal forms provided by the council and renewal fees defined in §810.5 of this title (relating to Fees).

(3) Registration certificate expiration. All registration certificates expire September 30, no matter the date of initial registration.

(4) Renewal application postmark date. All renewal applications must be postmarked by September 1 or a late fee shall be assessed.

(5) Continuing education activities. Registrants should request pre-approval of hours from the council before attending educational training. Continuing education activities shall be instructor-directed activities such as conferences, symposia, seminars and workshops and must be accepted or approved for continuing education credits by the licensing agencies regulating professionals listed in §810.3 of this title (relating to Registry Criteria).

(6) Home or self-directed study courses. No home or self-directed study courses will be considered for continuing education hours.

(7) Presentation of continuing education. All renewal applicants may count a maximum of four hours per renewal period for the presentation of continuing education training, lectures, or courses in the specific area of sex offender treatment and evaluation, sexual assault issues and/or victim training.

(8) Carrying over continuing education hours. No hours may be carried over from one renewal period to another renewal period.

(9) Continuing education extension.

(A) A registrant who has failed to complete the requirements for continuing education (CE) may be granted a 90-day extension by the executive director.

(B) The request for an extension of the CE period must be made in writing and must be postmarked prior to September 30.

(C) If an extension is needed a late fee equal to one-half of the renewal fee stated in §810.5(4) of this title will be assessed.

(D) The next CE period shall begin the day after the CE has been satisfied.

(E) Credit earned during the extension period cannot be applied toward the next CE period.

(F) A person who fails to complete the CE requirements during the extension or who does not request an extension holds an expired registration and may not use the RSOTP or ASOTP credential or certificate.

(10) Completion of continuing education after extension. A registration may be renewed upon completion of the required CE within the given extension period, submission of the registration form, and payment of the applicable late renewal fee.

(11) Failure to complete continuing education. A person who fails to complete CE requirements for renewal and failed to request an extension to the CE period may not renew the registration. The person may obtain a new registration by complying with the current requirements and procedures for obtaining a license.

§810.5. Fees.

The council has established the following registration fees.

(1) All applicants must submit a non-refundable annual application fee of $200 or a $400 for the biennium and a nominal electronic application fee if applicable, as established by the contracting agency and meet the following requirements for consideration and inclusion in the registry:

(A) return the completed, signed and notarized application form provided by the council;

(B) submit the registration fee in the form of a check or money order; and

(C) submit, within 90 calendar days, any documentation required to complete be submitted.

(2) Additional fees will be charged for Federal Bureau of Investigations and Texas Department of Public Safety criminal background checks. Fees shall be determined by those agencies conducting the investigation.

(3) Applicants that meet the specialized competency criteria and who chose to list those competencies listed in the registry will be charged an initial $20 non-refundable fee per specialty annually or $40 per specialty per biennium.

(4) Renewal forms and information will be mailed to each registrant at least 60 days prior to registration expiration and sent to the registrant's last address of record with the council.

(5) Registrants that meet the RSOTP supervisor criteria and want to be designated as an approved supervisor shall pay a $20 credentialing fee annually or a $40 credentialing fee per biennium.

(6) To renew, an RSOTP or an ASOTP shall submit an annual renewal fee of $100 or a biennial renewal fee of $200 and a nominal electronic renewal fee if applicable, as established by the contracting agency and shall meet the following requirements.

(A) A person who is otherwise eligible to renew a registration may renew an unexpired registration by paying the required registration fee to the council on or before the expiration date of the registration.

(B) Registrants wanting to continue to list their specialized competencies in the registry will be charged a $10 annual fee or a $20 biennial fee per specialty listed.

(C) If a registration has been expired for 90 days or less, the late renewal fee is equal to one and one-half times the required renewal fee.

(D) If a registration has been expired for longer than 90 days but less than one year, the reinstatement fee is equal to two times the require renewal fee.

(E) If a registration has been expired for one year or longer, the reinstatement fee is two times the required renewal fee.

(7) Effective January 1, 2004, for all applications and renewal applications, the council is authorized to collect subscription and convenience fees, in amounts determined by the Texas Online Authority, to recover costs associated with application and renewal application processing through the Texas Online.

(8) Effective January 1, 2004, for all applications and renewals, the council is authorized to collect fees to fund the Office of Patient Protection, Health Professions Council, as mandated by law.

§810.7. Documentation of Experience and Training.

In determining the acceptability of the treatment provider's experience and/or training, the council will require documentation of experience and/or training regarding the quality, scope, and nature of the applicant's work in sex offender treatment and rehabilitation. This will include 2 reference letters from professionals who can attest to the applicant's work in sex offender treatment. The council recognizes continuing education activities that are instructor-directed activities such as conferences, symposia, seminars and workshops and must be accepted or approved for continuing education credits by the licensing agencies regulating professionals listed in §810.3 of this title (relating to Registry Criteria).

§810.8. Revocation, Denial or Non-Renewal of Registration.

(a) The council shall have the right to revoke a registration, refuse to accept a registration, and/or refuse to renew a registration upon proof that the treatment provider has:

(1) been convicted of any felony or a misdemeanor involving a sexual offense, or has ever received deferred adjudication for a sexual offense, unless sufficient evidence of rehabilitation has been established as determined by the council;

(2) had his/her primary licensure placed on inactive status, not renewed, revoked, canceled, suspended, or placed on probationary status by any professional licensing body, unless sufficient evidence of rehabilitation has been established as determined by the council;

(3) been determined by any professional licensing body to have engaged in unprofessional or unethical conduct, unless sufficient evidence of rehabilitation has been established as determined by the council;

(4) been determined by the council to have engaged in deceit or fraud in connection with the delivery of services, supervision, or documentation of registry requirements or registry eligibility;

(5) violated the Act or any rule adopted by the council;

(6) been prohibited from renewal by the Education Code, §57.491 (relating to Loan Default Ground for Non-renewal of Professional or Occupational License); or

(7) been prohibited from renewal by a court order or attorney generals order issued pursuant to the Family Code, Chapter 232 (relating to Suspension of License for Failure to Pay Child Support).

(b) The council may take action against a registrant or deny an application or renewal if the registrant has felony or misdemeanor convictions.

(c) The following felonies and misdemeanors relate to a registrant because these criminal offenses indicate an inability or tendency to be unable to perform as a RSOTP:

(1) an offense involving moral turpitude;

(2) failure to report child abuse or neglect;

(3) a misdemeanor involving deceptive business practices;

(4) any felony or misdemeanor conviction involving a sexual offense, or having have received deferred adjudication for a sex offense;

(5) the felony offense of theft;

(6) any offense of assault; and

(7) any other misdemeanor or felony which would indicate an inability or tendency to be unable to perform as a RSOTP.

(d) Documentation of rehabilitation may include the following:

(1) court records related to the conviction;

(2) documents related to the sentence imposed;

(3) documents of completion of the sentence;

(4) documents of satisfactory completion of probation or parole;

(5) information about subsequent good conduct;

(6) letters of support from employers or others; and

(7) any other information that supports the applicant's qualifications.

§810.9. Complaints, Disciplinary Actions, Administrative Hearings and Judicial Review.

(a) Reporting a complaint. A person wishing to report an alleged violation of the Act or this chapter by a registrant or other person shall notify the executive director. The initial notification may be in writing, by fax, or by personal visit to the council office.

(b) Review of complaint.

(1) The executive director will review the complaint for violations of the Act or any rule adopted by the council.

(2) If it is determined that a violation of the Act or these sections may have occurred, the executive director or executive directors designee will:

(A) refer the complaint to the registrant's primary licensing agency within 60 days of the receipt of the complaint;

(B) notify the registrant or other person in writing, by phone or in person that a complaint has been filed; and

(C) notify the complainant in writing of receipt of the complaint.

(c) Responsibilities of registrant.

(1) A registrant shall cooperate with the council by furnishing required documents or information and by responding to a request for information or a subpoena issued by the council or its authorized representative.

(2) A registrant shall comply with any order issued by the council relating to the registrant. A licensee shall not interfere with a council investigation by the willful misrepresentation of facts to the board or its authorized representative or by the use of threats or harassment against any person.

(3) The subject of the complaint will be notified of the allegations either in writing, by phone or in person by the executive director or designee and will be required to provide a sworn response to the allegations within 14 calendar days of that notice.

(4) Failure to respond to the allegation within the 14-day period is evidence of failure to cooperate with the investigation and may subject the registrant to disciplinary action.

(d) Actions by the council. The council is authorized to revoke, suspend or refuse to renew a registration, place on probation a person whose registration has been suspended, or reprimand a registrant for a violation of the Act, or a rule of the council.

(e) Probated Suspension. If the suspension is probated, the council is authorized by Occupations Code, §13C(a)(1)-(3) of the Act to impose certain requirements and limitations on a person.

(f) Disciplinary action on primary license. If any professional license of the registrant is revoked or suspended, the council shall propose revocation of registration.

(g) Complaint information. The council shall keep information about each complaint filed with the council. The information shall include:

(1) the date the complaint is received;

(2) the name of the complainant;

(3) the subject matter of the complaint;

(4) a record of all witnesses contacted in relation to the complaint;

(5) a summary of the results of the review or investigation of the complaint; and

(6) for a complaint for which the Council took no action, an explanation of the reason the complaint was closed without action.

(h) Formal hearing.

(1) The formal hearing shall be conducted according to the provisions of the Texas Government Code, Title 10, General Government, Chapter 2001, Administrative Procedure Act and held in Travis County, Texas, unless otherwise determined by the Administrative Law Judge (ALJ) or upon agreement of the parties.

(2) Prior to institution of formal proceedings to revoke or suspend a registrant, the executive director shall give written notice to the registrant by certified mail, return receipt requested, of the facts or conduct alleged to warrant revocation or suspension, and the person shall be given the opportunity, as described in the notice, to show compliance with all requirements of the Act and this chapter.

(3) To initiate formal hearing procedures, the executive director shall give the registrant written notice of the opportunity for hearing. The notice shall state the basis for the proposed action. Within 10 days after receipt of the notice, the registrant must give written notice to the executive director that he or she either waives the hearing or wants the hearing. Receipt of the notice is deemed to occur on the 10th day after the notice is mailed to the registrant's last reported address unless another date of receipt is reflected on a U.S. Postal Service return receipt.

(A) If the registrant fails to request a hearing, the registrant is deemed to have waived the hearing, and a default order may be entered.

(B) If the registrant requests a hearing within 10 days after receiving the notice of opportunity for hearing, the executive director shall initiate formal hearing procedures in accordance with this section.

(i) Final action.

(1) If the council suspends a registration, the suspension remains in effect for the period of suspension ordered, or until the executive director or the council determines that the reasons for suspension no longer exist. The registrant whose registration has been suspended is responsible for securing and providing to the executive director such evidence, as may be required by the council, that the reasons for the suspension no longer exist. The executive director or the council shall investigate prior to making a determination.

(2) During the time of suspension, the former registrant shall return all registration certificates to the council.

(3) If a suspension overlaps a renewal period, the former registrant shall comply with the normal renewal procedures in these sections. The council may not renew the certificate until the executive director or the council determines that the reasons for suspension have been removed.

(4) A person whose application is denied or whose registration certificate is revoked is ineligible to apply for registration under this Act for one year from the date of the denial or revocation.

(5) Upon revocation or non-renewal, the former registrant shall return all certificate(s) and renewal card(s) issued to the registrant by the council. The certificate(s) and renewal card(s) shall be returned to the council by certified mail, hand-delivered, or by a delivery service, within 30 days of request.

(j) Appeal of a decision. A person may appeal a final decision of the council to exclude or remove the person from the registry by filing a petition for judicial review in the manner provided by the Government Code, §2001.176.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405276
Walter J. Meyers, M.D.
Chairperson
Council on Sex Offender Treatment
Effective date: September 12, 2004
Proposal publication date: June 4, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER B. CRIMINAL BACKGROUND CHECK SECURITY

22 TAC §§810.31 - 810.34

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. CRIMINAL BACKGROUND CHECK

22 TAC §§810.31 - 810.34

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.32. Records.

All other records of the council that are not made confidential by other law are open to inspection by the public during regular office hours. The contents of the criminal background check on each registrant are not public records and are confidential under lock and key security. Unless expressed in writing by the chairperson of the council, the executive director and the executive director's designee are the only staff authorized to have daily access to the criminal history records. These records will be maintained in separate files and not in the registrant files.

§810.33. Destruction of Criminal History Records.

The council shall destroy adjudication information relating to a person after the council makes a decision on the eligibility of the applicant unless the information was the basis for a proposed revocation, suspension or refusal to renew a person's registration. The council shall shred the information provided by the Texas Department of Public Safety, the Federal Bureau of Investigation or any other law enforcement agency, and the submitted applicant's fingerprint card.

§810.34. Frequency of Criminal Background Check.

The council shall conduct a criminal background check on every new applicant, randomly at the time of renewal, and as necessary on all others.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. STANDARDS OF PRACTICE

22 TAC §§810.61 - 810.64

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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22 TAC §§810.61 - 810.67

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.61. Introduction to Standards of Practice.

(a) The Council on Sex Offender Treatment (council) is dedicated to the prevention of sexual assault through effective treatment and management of sex offenders. The council identifies treatment providers who have the appropriate training and experience in the treatment of adult sex offenders and juveniles with sexual behavior problems, sponsors training seminars and conferences, and disseminates information regarding adult sex offenders and juveniles with sexual behavior problems and their treatment. The council publishes a registry of sex offender treatment providers, which contains the names of persons who have satisfactorily completed council requirements for inclusion.

(b) Sexual deviance is a learned or acquired behavioral disorder but may also be influenced by biological factors. Treatment is focused on recognizing, modifying and managing deviant behavior and the attitudes that promote it. Sexual deviance is not considered to be a disease that can be cured. The focus of contemporary treatment is on techniques designed to assist adult sex offenders and juveniles with sexual behavior problems in maintaining control throughout their lifetime. Therefore, treatment should include simple, practical techniques that can be used during and after formal treatment.

(c) Evaluation and treatment requires an approach unfamiliar to most mental health professionals. Treatment providers often exercise substantial control over the lives of their clients because of the concern for community protection. For this and other reasons, standards of practice specific to the treatment of these clients are necessary.

(d) This document was developed by the council to delineate appropriate evaluation and treatment procedures and policies. These standards were largely adopted by reference from the Association for the Treatment of Sexual Abusers (ATSA) publication entitled, Ethical Standards and Principles for the Management of Sexual Abusers, Revised 2004. They are not intended to supplant the standards of the treatment provider's licensing/certifying board, but are intended to supplement them. These standards delineate professional expectations for the treatment of adult sex offenders and juveniles with sexual behavior problems.

§810.62. Council Assertions.

(a) Registrants shall:

(1) be committed to community protection and safety and registrants shall be aware of any professional and legal obligations regarding a duty to protect or warn;

(2) not make statements that a client is no longer at any risk to reoffend (ATSA Standard);

(3) refuse referrals for re-evaluations to determine if someone is guilty or innocent of a specific sexual crime (ATSA Standard);

(4) recognize and when providing expert testimony, acknowledge that there is no known psychological or physiological test, profile, evaluation procedure, or combination of such tools that prove or disprove whether the client has committed a specific sexual crime (ATSA Standard);

(5) not discriminate against clients with regard to race, sex, religion, gender preference, choice of lifestyle, or disability;

(6) treat clients with dignity and respect, regardless of the nature of their crimes or conduct;

(7) be knowledgeable of legal statutes and scientific data relevant to this area of specialized practice;

(8) perform professional duties with the highest level of integrity, maintaining confidentiality within the scope of statutory responsibilities;

(9) insure that the client fully understands the scope and exceptions to confidentiality in the context of his or her particular situation;

(10) refrain from using professional relationships to further their personal, religious, political, or economic interest other than accepting customary professional fees;

(11) not engage in sexual relationships with clients;

(12) fully inform clients in advance of fees for services;

(13) refrain from knowingly providing treatment services to a client who is in treatment with another professional without initial consultation with the current registrant or non-registrant;

(14) make appropriate referrals when the registrant is not qualified or is otherwise unable to offer services to a client;

(15) insure that colleagues are qualified by training and experience before making a referral to them;

(16) when withdrawing services, minimize possible adverse effects on the client and the community by continuing treatment until the client has been admitted elsewhere;

(17) facilitate the provision of follow-up services for clients who transition from one program or one jurisdiction to another which includes a written summary of the assessment of risk, offending pattern, level of participation, relevant problems and treatment needs, client strengths and deficits, support group, and recommendations;

(18) take into account the legal/civil rights of the clients, including the right to refuse treatment;

(19) make no claims regarding the efficacy of treatment that exceed what can be reasonably expected and supported by empirical literature;

(20) avoid drawing conclusions or rendering opinions that exceed the present level of knowledge in the field or the expertise of the evaluator;

(21) attempt to resolve with the clinician and/or report to the appropriate licensing or regulatory authority unethical, incompetent, and dishonorable treatment or evaluation practices; and

(22) display or provide in writing the address and telephone number of the council in all sites where sex offender treatment services are provided for the purpose of directing complaints to the council.

(b) Registrants assert that:

(1) community safety shall take precedence over any conflicting consideration and ultimately, treatment providers shall act in the best interests of society, the victim, and the client;

(2) inappropriate or unethical treatment damages the credibility of all treatment and presents an unnecessary risk to the community;

(3) criminal investigation, prosecution, and court orders for treatment may be components of effective intervention;

(4) the containment model includes but is not limited to the communication, cooperation, exchange of information (Article 42.12 , Code of Criminal Procedure, §9, subsection (j), (k), and (l)) and coordination with community supervision officers, child protective services workers, law enforcement, polygraph examiners, survivor's therapists, support persons and is essential to community protection. This collaboration can increase the effectiveness of community risk management strategies. A close working relationship recognizes that sexual abuse is criminal behavior and that legal sanctions apply. Treatment targets and supervision conditions may be most effective when they are consistent with one another and should focus on criminogenic needs (ATSA Standard);

(5) a voluntary client accepted for treatment should be held to the same standards of compliance as are mandated adult sex offenders and juveniles with sexual behavior problems;

(6) it is imprudent to release an untreated client without providing offense-specific assessment and treatment or specialized supervision;

(7) without external pressure many clients will not follow through in treatment. Internal motivation improves the prognosis, but is not a guarantee of success;

(8) comprehensive assessment of the client shall precede treatment and includes issues addressed in §810.63 of this title (relating to Assessment/Evaluation Concerns);

(9) adult sex offenders and juveniles with sexual behavior problems require comprehensive, long term, offense-specific treatment. Currently, cognitive-behavioral approaches that utilize sex offender peer groups have been recognized as the standard method of treatment. Treatment groups shall be limited to 12 clients. Self-help groups, drug intervention, or time-limited treatment should be used only as adjuncts to more comprehensive treatment. For some sex offenders, incarceration without treatment may increase the risk of recidivism;

(10) a written initial individualized treatment plan that identifies the issues, intervention strategies, and goals of treatment shall be prepared for each sex offender within 30 days of the referral. Treatment plans should be reassessed at least annually;

(11) the treatment plan may include behavioral contracts which outline specific expectations of the client, his/her family, and the client's support systems. These contracts shall include provisions to avert high-risk situations. These contracts shall be reassessed periodically;

(12) progress, or lack thereof, should be clearly documented in treatment records. Specific achievements, failed assignments and rule violations should be recorded. This information should be provided to the appropriate supervising officer in the justice system;

(13) progress in treatment must be based on specific, measurable objectives, observable changes, and demonstrated ability to apply changes in relevant situations. For most adult sex offenders and juveniles with sexual behavior problems, progress requires changes in the client's behavior, attitudes, social and sexual functioning, cognitive processes, and sexual arousal/preference patterns. These changes should be demonstrated by an increased understanding by the client of his/her own deviant behavior, understanding of current and instant offense cycle, increase in pro-social behaviors, compliance with supervision, increase in support systems, sensitization to the effects on a survivor, and ability to seek and apply help;

(14) when a client has made the changes required in treatment, there should be a gradual and commensurate decline of intervention, support, and supervision following an offense-specific treatment program. Ongoing support to maintain changes made in treatment is necessary and aftercare and monitoring are desirable;

(15) there will be instances when the registrant should refuse to treat a client because essential ancillary resources do not exist to provide the necessary levels of intervention or safeguards;

(16) the registrant has an ethical obligation to refer the client to a more comprehensive treatment program and/or to the judicial system, when the registrant determines that a sex offender is not making the changes necessary to reduce his/her risk to the community;

(17) registrants shall communicate to the supervising officer in the justice system, failure on the part of clients to abide by their treatment plans and/or contracts;

(18) a registrant may decide to decline further involvement with a client who refuses to address any critical aspect of treatment;

(19) registrants shall immediately notify the appropriate authority when a client drops out of court-ordered treatment;

(20) most adult sex offenders and juveniles with sexual behavior problems enter the criminal justice system with varying degrees of denial regarding their behavior. Overcoming denial is a gradual process achieved in treatment. The existence of some degree of denial shall not preclude an offender entering treatment, although the degree of denial shall be a factor in identifying the most appropriate form and location of treatment;

(21) treatment is unlikely to be effective unless the client admits his/her behavior. Community based treatment may not be appropriate for sex offenders who continue to demonstrate complete denial after a trial period of treatment;

(22) registrants shall not rely exclusively on self report by the sex offender to assess progress or compliance with treatment requirements and/or probation or parole orders. Registrants shall rely on multiple sources of information which may include physiological methods such as polygraph, phallometric, and other research based sexual arousal/preference assessments including but not limited to the Card Sort or visual reaction time methods;

(23) physiological methods or sexual arousal/preference assessment should not replace other forms of monitoring but may improve accuracy when combined with active surveillance, collateral verifications, and self-report. Penile plethysmograph assessments in Texas shall be conducted by an order and under the supervision of a physician. Physiological methods or sexual arousal/preference assessments cannot be used to prove an individual did or did not, or will or will not commit a sexual offense. The strongest predictor of sexual offense recidivism for child molesters are measures of deviant sexual arousal as measured by phallometric assessment (Hanson and Bussiere 1998);

(24) polygraph examinations shall only be conducted by licensed examiners that meet and adhere to the "Recommended

Guidelines for the Clinical Polygraph Examinations of Sex Offenders" as developed by the Joint Polygraph Committee on Offender Testing (JPCOT). Polygraphs are effective in encouraging disclosure of prior events and adherence to rules. This procedure should never be the only method used to determine factual information; Sexual history polygraphs are effective in determining a client's risk to the community. Disclosure polygraphs about the instant offense cannot be conducted without the official offense report. The Registrant shall have this report in order to adequately prepare the client for the polygraph. Additionally, the polygraph examiner shall have the official report in order to conduct the polygraph examination;

(25) informed, voluntary consent shall be obtained prior to engaging clients in aversive conditioning;

(26) removal of an interfamilial sex offender against children from a residence in which children reside (instead of the children) is the preferred option;

(27) treatment referrals should be offered to the non-offending partners and children in cases where a parent or legal guardian has been removed;

(28) top priority shall be given to the rights, well-being, and safety of children when making decisions about contact between the client and children. If the client has a history of sexual arousal to or reported fantasies of sexual contact with children, he or she should be restricted from having access to children. Supervised visits may be considered if:

(A) it is determined that sufficient safeguards exist;

(B) the sex offender has demonstrated control over his or her deviant arousal;

(C) it does not impede the sex offender's progress in treatment; and

(D) court mandated conditions do not prohibit such contact;

(29) there is evidence to support family participation in the treatment of the adult sex offender and the juvenile with sexual behavior problems. Where feasible and appropriate, spouses and other family members should be included. Sexual assault survivors or vulnerable children should be excluded until such time as joint therapy is determined to be appropriate;

(30) registrants shall assist in the selection and education of the potential chaperones for contacts between the client and children. Potential chaperones should only be adults who accept and understand the client's present sexual offense, past sexual offending, and the potential for sexual re-offense. Registrants shall ensure potential chaperones are educated regarding the client's sexual history, treatment and supervision conditions, antecedents to sexual offending, safety plans, relapse prevention, and reporting procedures. Registrants shall review a detailed safety plan with the child's non-offending parent or legal guardian that describes the appropriate levels of supervision for contact, privacy, discipline practice, sexual education, appropriate dress, hygiene, bedtime routines, conditions and limits that may apply, and how contact will be terminated if it is no longer appropriate for the child (ASTA Standard);

(31) the registrant shall make every effort to collaborate with the survivor's therapist in making decisions regarding communication, visits and reunification. Registrants shall be sensitive to the survivor's wishes and needs regarding contact with the offender. Contact shall be arranged in a manner that places child/victim safety first. When assessing child safety, both psychological and physical well-being shall be considered. The registrant shall ensure that custodial parents or legal guardians of the children have been consulted prior to authorizing contact and that contact is in accordance with Court directives; and

(32) if reunification is deemed appropriate, the process shall be closely supervised. There must be provisions for monitoring behavior and reporting rule violations. A survivor's comfort and safety shall be assessed on a continuing basis. The registrant shall recognize that supervision during visits with children is critical for those whose crimes are against children, or who have demonstrated the potential to abuse children. The supervisor of the contact shall be knowledgeable concerning sexual offending behaviors.

§810.63. Assessment/Evaluation Concerns.

(a) The evaluation focuses on both the risks and needs of the client, as well as identifying factors from social and sexual history, which may contribute to sexual deviance. Evaluations provide the basis for the development of comprehensive treatment plans and should provide recommendations regarding the intensity of intervention, specific treatment protocol needed, amenability to treatment, as well as the identified risk the adult sex offender and the juvenile with sexual behavior problems presents to the community. There is no known set of personality characteristics that can differentiate the sex offender from the non-sex offender. Psychological profiles cannot be used to prove or disprove an individual's propensity to act in a sexually deviant manner.

(b) The following standards were largely adopted by reference from the Association for the Treatment of Sexual Abusers publication entitled, Ethical Standards and Principles for the Management of Sexual Abusers, Revised 2004. Evaluations shall precede treatment. In preparing evaluations of sex offenders; registrants are expected to:

(1) be fair and impartial, providing objective and accurate data;

(2) respond only to referral questions that fall within the evaluator's expertise and present level of knowledge;

(3) be respectful of the client's right to be informed of the reasons for the evaluation and the interpretation of data, as well as the basis for recommendations and conclusions;

(4) be aware of the client's legal status;

(5) be mindful of the limitations of client's self-report and make all possible efforts to verify the information provided by the client;

(6) use evaluative procedures and techniques sufficient to respond to the presenting issues, as well as to provide appropriate substantiation for the resulting conclusions and recommendations;

(7) acknowledge if an evaluation consisted of only a review of data, with no client contact, and clarify the impact that limited information has on the reliability and validity of the resulting report;

(8) provide informed consent, releases and/or limit of confidentiality documents in written form and employ verbal explanations for non-readers;

(9) thoroughly review written documentation and collateral interviews. This involves gathering and reviewing information from all available and relevant sources, including:

(A) criminal investigation records;

(B) child protection service investigations;

(C) previous evaluations and treatment progress reports;

(D) mental health records and assessments;

(E) medical records;

(F) correctional system reports;

(G) probations/parole reports;

(H) information regarding details of the offense as obtained by law enforcement; and

(I) offense statements from victim.

(10) whenever possible, interview the client's significant other and/or family of origin;

(11) cautiously interpret evaluation conducted without collateral information;

(12) list and acknowledge in a written report evaluation procedure summaries, conclusions, recommendations, and all collateral reports and interviews;

(13) re-interviews of survivors should not be used for the purpose of gathering information during the sex offender's evaluation; and

(14) keep the sex offender and survivor's interview and evaluation processes separate. If that is not possible, the evaluator must be extremely vigilant to avoid bias.

(c) The evaluation procedures includes:

(1) clinical review;

(2) paper/pencil testing;

(3) intellectual assessment; and

(4) physiological assessments.

(d) A reasonable effort shall be made to acquire the following information gathered in the evaluation process:

(1) intellectual and cognitive functioning;

(2) mental status and psychiatric history;

(3) medical history of head injuries, physical abnormalities, enuresis, encopresis, current use of medication, allergies, accidents, operations, and major medical illnesses;

(4) self-destructive behaviors, self-mutilation, and suicide attempts;

(5) psychopathology and personality characteristics;

(6) family history and marital/relationship history;

(7) history of victimization; physical, emotional and/or sexual;

(8) education and occupation history;

(9) criminal history;

(10) history of violence and aggression including use of weapons;

(11) history of truancy, fire-setting, and abuse of animals;

(12) interpersonal relationships, both past and current;

(13) cognitive distortions;

(14) social competence;

(15) impulse control;

(16) substance abuse;

(17) official report regarding the instant offense;

(18) denial, minimization and inability to accept responsibility;

(19) sexual history, including sexual development, adolescent sexuality and experimentation, dating history, intimate sexual contacts, gender identity issues, adult sexual practices, masturbatory practices, sexual dysfunction, fantasy content, and sexual functioning; and

(20) sexually deviant behavior, including description of offense behaviors, number of victims, gender and age of victims, frequency and duration of abusive sexual contact, victim selection, access, and grooming behaviors, use of threats, coercion or bribes to maintain victim silence, degree of force used before, during and/or after offense, and sexual arousal patterns.

(e) Registrants shall subscribe to the following tenets regarding client assessment.

(1) The comprehensive assessment of the client's sexually deviant behavior is specific to the on-going assessment of the client.

(2) It is important to be sensitive to the individual's cognitive functioning, including reading and writing capabilities, prior to arranging the battery of testing instruments.

(3) If a client cannot read at the level necessary to comprehend the test questions, arrangements for using a standardized approved auditory (taped or read) version of the test instrument should be made, to the extent such versions are available.

(4) The clinical interview must incorporate sufficient discussion necessary to augment, clarify and explore the information obtained from the review of collateral materials (and interviews), as well as the other components of the evaluation (testing results, etc.).

(5) It is important to note the degree of similarity or disparity between the abuser and the victim's statements. Registrants must have the official offense report for this comparison.

(6) The client's explanations for false allegations should be documented.

(7) Assessment of treatment needs should identify strengths and weaknesses in the individual's psycho-sexual functioning for the purpose of directing treatment efforts to the appropriate areas.

(8) Both community safety and the degree to which a client is capable and willing to manage risk should be considered when generating recommendations.

(9) A thorough evaluation should be completed prior to a client being accepted into a community based treatment program.

(A) If a significant amount of time has lapsed between the completions of the evaluation and when the individual applies for acceptance into a treatment program, an evaluation update is required.

(B) The intent of the update should not be to duplicate the original evaluation, but to gather current data upon which the original treatment plan can either be confirmed or amended.

(10) A sex offender treatment provider should never recommend an inadequate treatment program or level of risk management because existing resources limit or preclude adequate or appropriate services.

§810.64. Juveniles with Sexual Behavior Problems.

(a) Council Assertions.

(1) Some children begin displaying sexually inappropriate behavior with others before they reach 10 years of age. Others may copy sexual behavior they have witnessed on the part of older siblings

and/or adults. Therefore, early identification and treatment are essential for those who have displayed such behaviors.

(2) The onset of sexual behavioral problems in juveniles can be linked to numerous issues related to their experiences, exposure, and/or developmental deficits. Juveniles are distinct from their adult counterparts.

(3) Only a minority of juveniles manifest established paraphilic sexual arousal and interest patterns. These arousal and interest patterns are recurrent and intense, and related directly to the nature of the sexual behavior problem. In general, sexual arousal patterns of juveniles appear more changeable than those of adult sex offenders and relate less directly to their patterns of offending behavior.

(4) The treatment of juveniles with sexual behavior problems has the following components that are essential to the successful treatment of the juvenile. The program should include a comprehensive assessment, progressive levels of treatment and education, relapse prevention, transition into the community, and aftercare. In order to effectively treat juveniles with sexual behavior problems the treatment must be offense specific.

(5) Working with juveniles should be based on a multidisciplinary approach and containment model that includes but is not limited to the juvenile, family, treatment provider, supervision officer, school officials, law enforcement, and the victim's therapist (if possible). On-going communication (written and verbal) is essential in the successful treatment of the juvenile.

(6) Treatment providers should focus on the juvenile's existing strengths and positive support system to promote pro-social behaviors and facilitate change.

(7) Juveniles with sexual behavior problems come from all socio-economic, ethno-cultural, age, and religious backgrounds. They vary in their level of intellectual functioning, motivation, victim typology, and sexual behaviors.

(8) Treatment referrals should be offered to the non-offending guardians/parents and siblings where a juvenile has been removed.

(9) Juveniles who display sexually abusive behavior are effectively addressed by targeting risk factors that predispose a child to sexual behavior problems or that precipitate or perpetuate the problems.

(10) Special interventions are necessary for juveniles with intellectual and cognitive impairments.

(11) Juveniles who display sexually abusive behavior are heterogeneous groups who have developmental needs, but also have special needs and present special risks related to their abusive behaviors.

(12) Risk management strategies are effective in addressing the needs underlying the juvenile's behavior such as, but not limited to, child safety zones and/or plans, arousal modification, polygraphs, and sex education.

(13) The primary goal is helping juveniles gain control over their sexual behavior problems and increasing their pro-social interactions, preventing further victimization, halting development of additional psychosexual problems, and helping the juvenile develop age-appropriate relationships. They are children and adolescents first.

(14) Programs that only focus on sexual behavior problems are of limited value and researchers have recommended a holistic approach as in this section.

(b) Juvenile Evaluation.

(1) The evaluation shall focus on strengths, the risks, and deficits of the juvenile with sexual behavior problems, as well as identifying factors from social and sexual history, which may contribute to sexual deviance. Evaluations provide the basis for the development of comprehensive treatment plans and should provide recommendations regarding the intensity of intervention specific treatment protocol needed, amenability to treatment, as well as the identified risk the juvenile with sexual behavioral problems presents to the community. There is no known set of personality characteristics that can differentiate the juvenile with sexual behavioral problems from the juvenile without sexual behavioral problems. Psychological profiles cannot be used to prove or disprove an individual's propensity to act in a sexually deviant manner. A comprehensive evaluation and assessment of juveniles with sexual behavior problems is an ongoing process.

(2) The treatment of juveniles with sexual behavior problems is effective in reducing recidivism. In order for treatment to be effective, it must incorporate both cognitive/ behavioral and relapse prevention approaches. A multifaceted program includes the following:

(A) group and individual cognitive behavioral therapy;

(B) offense cycle/relapse prevention;

(C) family therapy;

(D) victim empathy;

(E) adjunct therapy including substance abuse treatment, anger and stress management, conflict resolution, sex education, social competence/life skills, clarifying, values, trauma resolution, problem solving, impulse control and interpersonal communication;

(F) psychopharmacological approaches (if appropriate);

(G) polygraphs (Family Code, Chapter 54, §54.0405); and

(H) and plethysmographs (if appropriate).

(3) When using phallometric assessment or aversive treatment techniques with persons 17 years of age or younger, consent for such assessment and treatment should be obtained from the juvenile with sexual behavior problems and written consent for such assessment and treatment should be obtained from the juvenile's parents or legal guardians, and the procedures should be reviewed by a multi-disciplinary professional or institutional advisory group. This is intended to ensure that individuals not intimately involved in the treatment of the patient have input regarding the appropriateness of such methods consistent with the developmental level of the child. Stimuli must be specific for use with adolescents.

(4) The use of the plethysmograph with juveniles is an issue of some controversy. Research indicates that the age and level of denial of the juvenile may compromise the validity of the assessment. Younger juveniles appear to produce less reliable patterns of responding, and those who deny their offenses tend to produce suppressed, and therefore non-interpretable patterns of arousal (Becker et al, Kaeming et al, 1995).

(5) Individuals that are pre-pubertal or under age 13 should not undergo phallometric assessment or aversive treatment except in rare cases, which must be approved by a multi-disciplinary advisory group. Prepubescent juveniles are sexually aroused to a wide variety of stimuli.

(6) Written consent shall be obtained for assessment and information exchange from the appropriate parent or legal guardian.

Assent from the individual being evaluated should be obtained whenever possible.

(c) Initial Juvenile Assessment.

(1) The assessment shall be age appropriate.

(2) The assessment shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, medical and/or educational issues that may arise during the evaluation.

(3) The assessment shall be developmentally appropriate which includes social, cognitive, and educational levels.

(4) A reasonable effort should be made to acquire the following information gathered in the assessment process:

(A) intellectual and cognitive functioning;

(B) mental status psychiatric history/hospitalization;

(C) medical history and an exam by a medical professional to determine sexual development;

(D) self destructive behaviors including self-mutilation and suicide attempts;

(E) family origin and history/ relationship history including exposure to domestic violence;

(F) criminal history;

(G) sex offender registration status;

(H) history of violence and aggression;

(I) history of school truancy, fire-setting, abuse of animals, and running away;

(J) cognitive distortions;

(K) impulse control;

(L) trauma assessment (emotional, physical, sexual abuse);

(M) social and educational competence;

(N) substance abuse;

(O) official reports regarding instant offense (Family Code, Chapter 54, §54.0405);

(P) sexual history including sexual development, sexuality and experimentation, gender identity issues, masturbatory practices, and fantasy content; and

(Q) sexually deviant behavior-including a description of the offense behaviors, number of victims, gender and age of victims, frequency and duration of sexual contact, victim selection, access, grooming behaviors, use of threats, coercion or bribes to maintain victim silence, degree of force used before, during and/or after the sexual behavior, and deviant arousal patterns.

(d) Collateral Information. The treatment provider shall thoroughly review written documentation and collateral interviews. This involves gathering and reviewing information from all available and relevant sources concerning the juvenile and the victim, including:

(1) parent or guardian;

(2) sibling;

(3) statements from the victims;

(4) school records;

(5) child protective service;

(6) previous treatment provider;

(7) mental health professional;

(8) law enforcement; and

(9) the following information should be provided from the supervision officer:

(A) exchange of formal documentation;

(B) order or judgment;

(C) victim information;

(D) juvenile risk assessment; and

(E) data collection form.

(e) Use of Psychological Tests. Psychological tests have been described as a "critical dimension" to a comprehensive evaluation of juveniles. The primary domains required in the assessment of the juvenile are as follows:

(1) intellectual and neurological functioning;

(2) personality (for example: Jesness Inventory, MACI, Minnesota Multiphasic Personality Inventory-MMPI for Juveniles);

(3) psychopathology (for example: Piers Harris Children's Self Concept Scale, Hare Psychopathy Scale - Youth Version);

(4) behavioral;

(5) sexual deviance; and

(6) co-morbidity.

(f) Risk Assessments. Current existing risk assessments should be used but the ultimate determination should be a combination of the clinical interview and the assessment instruments. A strong predictor of risk is the sexual history polygraph. The sex history provides information about the juvenile's sexual behaviors and victims.

(1) It should be noted that no juvenile risk assessment is currently validated so no decision can be based solely on their outcomes.

(2) Risk assessment data is not useful for longer than 6 months due to the fluidity of juveniles.

(3) Family support and structure are important in reducing risk for re-offense.

(4) Research on recidivism indicates juvenile's recidivate at relatively low rates in relation to new sexual offenses.

(5) Risk Assessments specific to juveniles are available in the public domain are as follows:

(A) Estimate of Risk of Adolescent Sexual Offense Recidivism- ERASOR;

(B) Juvenile Sex Offender Assessment Protocol-JSOAP;

(C) Child and Adolescent Needs and Strengths Sexual Development;

(D) Texas Juvenile Risk Assessment Instrument and Data Collection Form. (These can be obtained from the Probation Department);

(E) J-RAT; and

(F) Protective Risk Factor Scale.

(g) Substance Abuse. It is important to use a valid and reliable assessment tool to screen for substance abuse problems in determining if the substance use is a risk factor in the sexual behaviors. The assessment tool is the Substance Abuse Subtle Screening Inventory (SASSI).

(h) Polygraphs. Polygraphs are used to facilitate more complete disclosures of sexual behaviors and to monitor compliance with treatment and supervision. The polygraph is an essential tool in offender accountability and honesty.

(1) Polygraphs must be administered on a voluntary basis and with informed consent unless court ordered (Family Code, Chapter 54, §54.0405).

(2) Polygraphs shall follow JPCOT guidelines.

(3) Polygraphs should never be the only method used to determine factual information.

(4) Most practitioners using the polygraph indicate that the age threshold for use with juveniles is approximately 14 years old.

(5) The following polygraphs should be conducted: Disclosure, Sexual History, Maintenance, and Monitoring.

(i) Assessment Recommendations. The following issues shall be addressed:

(1) the juvenile's strengths, risks, and deficits; and

(2) co-morbidity, placement, education/vocational needs, parent and family issues, substance abuse issues, and supervision.

(j) If the juvenile has a history of sexual arousal to reported fantasies of sexual contact with children of a particular age/gender group, he or she should be restricted from having unsupervised access to children in that identified target population. Supervised visits may be considered if:

(1) court mandated conditions do not prohibit such contact;

(2) it is determined that the sufficient safeguards exists including but not limited to safety plans approved by the treatment provider and supervision officer;

(3) the juvenile has demonstrated control over their deviant arousal; and

(4) it does not impede the juvenile's progress in treatment.

(k) Juvenile Laws. Treatment providers shall be familiar with the following laws concerning juveniles with sexual behavior problems.

(1) Occupations Code, Chapter 503.

(2) Health Insurance Portability and Accountability Act.

(3) Texas Family Code, Title 3, Chapter 51 et seq.

(4) Texas Family Code, §153.076-Duty to Provide Information.

(5) Code of Criminal Procedure, Chapter 62, Sex Offender Registration.

§810.65. Adult Female Sex Offenders.

The following are the council assertions regarding female sex offenders.

(1) A containment approach requires the integration of a collection of attitudes, expectations, laws, policies, procedures, and practices that have clearly been designed to work together.

(2) Due to the difficulties inherent in treating sex offenders and the potential threat to community safety, sex offense specific treatment should continue for several years, followed by a lengthy period of aftercare and monitoring. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates.

(3) Although the majority of sex offenders are male, it is clear that female sex offenders exist and that this population of offender is largely unrecognized and neglected. This lack of attention is regrettable for those who have been victimized by females.

(4) There is a paucity of professional literature and clinical practice that describes the needs of the female sex offender. Professional literature often presents females as victims even when they are identified as perpetrators.

(5) A female as a sex offender is an idea that society has difficulty acknowledging and it challenges society's beliefs about females. The notion of females as aggressive, exploitive, violent, and deviant offenders is not compatible with society's picture of women as mothers, sisters, wives, and the "gentler sex". Many professionals do not accept the idea that females would use their position and power in this manner. This creates a professional and cultural state of denial.

(6) It is estimated that females commit 12% of all sexual offenses against victims under the age of 6 and 6% of the sexual offenses against children between 6 and 12 years old (Snyder, 2000).

(7) It is estimated that 64% of the sexual abuse committed by females were crimes against biological relatives and 19% were against victims who were unrelated to the offender (Saradjian, 1996). The age of onset of the abuse was 3.2 years old (Rosencrans, 1997).

(8) It is imperative that providers balance treatment issues with offender accountability to the victims and the community at large.

(9) There are some similarities and differences between male and female sex offenders.

(10) Female Sex Offenders come from all social and economic classes (Saradjian, 1996).

(11) Women have deviant arousal that can lead to sexual abuse. Some females have gained sexual pleasure from their offending.

(12) Women shall be assessed for deviant sexual interest/arousal to ensure public safety.

(13) Information regarding sexual interest/arousal is obtained from self-report that can be polygraphed.

(14) Recent findings strongly challenge the belief that female sex offenders are rarely violent (Marvasti, 1986, Johnson and Shrier, 1987). Seventy percent of the female sex offenders in this study used extraneous violence against their victims. It is important to acknowledge that this population of female sex offenders does exist.

(15) Some female sex offenders offend violently on their own or in the company of males.

(16) Society should become more alert to the sexual abuse of acquaintances and strangers in addition to family members. Treatment programs for females reveal that programming specific to their needs requires attention. There needs to be research and development of programs concerning female sex offenders.

(17) The future challenge is to treat the female sex offender and not enable them by providing excuses or exemptions for their aberrant behaviors and sexual crimes.

(18) Evaluations and treatment planning should be based on a combination of the Clinical Interview and the assessment instruments. There are no valid risk assessments specifically for females at this time.

(19) Programs that only focus on sexual behavior problems are of limited value and researchers have recommended a holistic approach as in §810.64 of this title.

(20) In assessing and evaluating female sex offenders, registrant shall refer to the appropriate rules in §810.63 or §810.64(b) and (c) of this title.

§810.66. Developmentally Delayed Clients.

(a) The management and treatment of clients with developmental disabilities is a developing specialized field. Currently many decisions regarding standards of practice must be made in the absence of clear research outcomes.

(b) These standards are based on the best practices known and designed to minimize any threat the client may pose to the community.

(c) There are many terms used to refer to the population of individuals with limited intellectual functioning, including developmentally delayed, developmentally handicapped, mentally ill, and mentally retarded.

(1) Definitions.

(A) Adaptive behavior--The effectiveness with which a person meets the standards of personal independence and social responsibility reasonably expected of the person's age and cultural group.

(B) Developmental disability--A severe and chronic disability that is attributable to a mental or physical impairment or a combination of physical and mental impairments, is manifested before age 22, is likely to continue indefinitely, and results in substantial functional limitations in three or more of the major life activities.

(C) Mental illness--An illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that substantially impairs a person's thoughts, perception of reality, emotional process, or judgment or grossly impairs behavior as demonstrated by recent disturbed behavior.

(D) Mental retardation--A significantly sub-average general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.

(E) Sub-average general intellectual functioning--Refers to measured intelligence on standardized psychometric instruments of two or more standard deviations below the age-group mean for the tests used.

(2) Council Assertions.

(A) A containment approach requires the integration of a collection of attitudes, expectations, laws, policies, procedures, and practices that have clearly been designed to work together.

(B) The presence of developmental disabilities does not minimize the risk for any client, nor does it mitigate the trauma experienced by sexual assault victims.

(C) Managing the risk, behavioral interventions, and the imposition of appropriate external controls should be a priority for clients with disabilities.

(D) There is nothing inherent in the presence of developmental disabilities that cause sexually deviant behavior and nothing inherent in developmental disabilities, which inoculates from sexually deviant behavior.

(E) Clients with disabilities should be offered treatment that is appropriate to their developmental capacity, their level of comprehension, and the ability to integrate treatment components.

(F) The prevalence of sexually deviant behavior among this population is not known and might be due in part to mental health service professional's reluctance to label the behavior.

(G) Studies suggest that developmentally delayed sex offenders have an overall offense pattern that is similar to non-delayed adult sex offenders or juveniles with sexual behavior problems.

(H) Developmentally delayed sex offenders are distinguished from non-delayed clients in that they display significantly more social skill deficits, are sexually naïve, lack interpersonal skill, have a higher incidence of family psychopathology, psychosocial deprivation, school maladjustment, and more psychiatric illness, and delinquent or criminal behavior (Health Canada, 2000).

(I) Progress in treatment and ability to integrate the components of treatment is generally slower for these clients. The need for simple, direct language, the presence of concrete thinking, difficulty with concepts and abstractions, and the need for frequent repetition are common requirements.

(J) Group therapy is considered the best intervention and consideration should be given to the level of functioning when considering placement in groups. The single best indicator of the ability to function in this context is the client's actual functioning in a group setting.

(K) In cases where the client's level of functioning is determined to be too low for group treatment, the use of more individually oriented behavioral interventions coupled with external containment strategies might be used exclusively.

(L) If a client is unable to conceptualize the sequential cycle portion of the traditional relapse prevention plan, a reasonable alternative would be to focus on identifying risk situation or behaviors and appropriate interventions.

(M) Special needs groups should be limited to 8 clients and should be no longer than 90 minutes in duration. It may be necessary to conduct group twice per week.

(N) Clients who remain in significant denial and/or are extremely resistant to treatment after the finite period of extension determined by the treatment and supervision team should be terminated if they pose a continued risk to the community.

(O) Removal of a client from a home in which children are at risk is the recommended action. In balancing the needs of the client against the safety of the children, the safety of the children takes precedence.

(P) When treating developmentally delayed clients who have committed a sexual offense, it is essential to recognize their vulnerabilities and their risk of victimization by non-delayed clients.

(3) Assessments of the Developmentally Delayed Offender.

(A) Age equivalent assessment scoring does not correlate to sexual behavior in adults and registrants should guard against justifying sexually deviant behavior by indicating that the age equivalence score for any client has any relation to his or her victim typology.

(B) Legally, developmentally delayed clients must be given the opportunity to exercise their right to make a voluntary and informed decision to participate in treatment. A client must be fully informed of the nature of the treatment, the benefits and the available

options. In cases of intellectually handicapped sex offenders who are unable to give written consent, an interdisciplinary review and parent's or legal guardian's written consent must be obtained for permission to proceed with treatment.

(C) There is limited data available regarding the use of the plethysmograph with developmentally delayed offenders. There is evidence that these clients tend to respond with generally higher levels of sexual arousal during testing. Caution should be used regarding interpretation and validity. Registrants should utilize a stimulus package appropriate to the client's developmental level.

(D) Visual reaction time measures should only be used with clients who have an IQ score sufficiently high to achieve valid and reliable test results. The Relapse Prediction Scores of the Abel should not be used as a part of the assessment since it uses a questionnaire not adapted for this population.

(E) Prior to conducting polygraph examinations on these clients the polygraph examiner should collaborate with the treatment provider and the supervision officer to assess the client's ability to understand the concepts of truthfulness and deception or lying and the capacity to anticipate negative consequences based on deceptive responses. Results of polygraphs are more likely to reflect an error with this population and steps should be taken to have a second polygraph when results are inconclusive or deceptive and could result in termination or revocation.

(F) Polygraph examiners should design questions; conduct the pre-test, the examination, and the post-test at a level appropriate to the client's development.

(G) The assessment should determine the client's level of functioning, appropriate treatment interventions, and facilitate the development of an individualized treatment plan. The assessment should include:

(i) current level of functioning:

(I) cognitive and behavior functioning;

(II) level of planning the crime of conviction and other sexual history (Structured Interview, Collateral Information);

(III) expressive and receptive language skills (for example: Peabody Picture and Vocabulary Test Revised (PPVT-R);

(IV) social judgment, adaptive skills, and moral reasoning;

(V) sexual knowledge;

(VI) adaptive behavior (for example: Vineland Adaptive Behavioral Scale, Adaptive Behavioral Scale of the American Association for Mental Retardation);

(VII) criminal behavior (for example: Jessness Inventory, Criminal History);

(VIII) attention deficit (for example: Conners Test, Clinical Evaluation);

(IX) ability to function in groups (observation of functioning, collateral information);

(X) support systems (Current MHMR system involvement, family involvement, social involvement);

(XI) environmental or contextual factors that contribute to or maintain the behavior; and

(XII) trauma assessment (emotional, physical, sexual abuse).

(ii) official offense report/offense description:

(I) age and relation to the victim;

(II) details of the offense;

(III) past criminal behavior and/or sexually inappropriate behavior;

(IV) deviant sexual interest; and

(V) the extent of denial and cognitive distortions.

(iii) pertinent history:

(I) developmental history;

(II) family, marital, relationship, and personal background;

(III) medical, psychological and/or psychiatric/ hospitalization history;

(IV) educational history;

(V) occupational history;

(VI) substance use or abuse;

(VII) self-destructive behaviors, self-mutilation, and suicide attempts; and

(VIII) history of truancy, fire-setting, abuse of animals, and running away.

(4) Treatment of the Developmentally Delayed.

(A) Treatment components for developmentally delayed clients are based on those used in treating non-developmentally delayed clients but are tailored to address the learning limitations and special issues compounding these clients.

(B) Treatment programs should address the obstacles such as lack of opportunity to learn appropriate sexual behavior at an early age, high probability of past sexual victimization, social isolation, poor community acceptance of healthy sexual relationships, and difficulty in learning complex social rules and norms relating to dating, and intimacy.

(C) Cognitive behavioral therapeutic approaches are effective when paired with the cognitive strengths and weaknesses of the client.

(D) The development of appropriate social and sexual skills is critical in reducing the client's risk to re-offend. Treatment should include concrete skill building related to social interaction and sexual behavior and sex education.

(E) Structured activities to practice social skills may be required to facilitate the client's healthy development with peers.

§810.67. Pertinent Issues to Be Addressed in Treatment (Adults and Juveniles).

(a) The field of sex offender assessment and treatment has evolved based on extensive research and clinical experience.

(b) Interventions are designed to assist the individual to effectively manage thoughts, feelings, attitudes, and behaviors associated with their risk to reoffend. Structured, cognitive behavioral skills-oriented treatment programs that target specific criminogenic needs appear to be the most effective approaches in reducing rates of reoffending (ATSA Standard). The following treatment components generally are accepted as those most important to the effective treatment of sexual deviancy.

(1) Arousal Control. Control of deviant arousal, fantasies, and urges is a priority with most adult sex offenders and juveniles with sexual behavior problems. Fantasy and sexual arousal to fantasy are precursors to deviant sexual behavior. It should be assumed that most adult sex offenders and juveniles with sexual behavior problems have gained sexual pleasure from their specific form of deviance. Arousal control methods do not eliminate but only help control arousal. It is therefore necessary that clients learn to apply these techniques in everyday situations. Arousal control may require periodic "follow up" sessions for the remainder of the client's life. Effective arousal control must also include methods to control spontaneous deviant fantasies and to minimize contact with stimulating objects or persons. Arousal control should proceed from the most effective methods for reducing arousal to less effective methods. To document changes in arousal control, physiological measurement is essential. Multiple measures over time are required to determine change reliability.

(2) Cognitive Therapy. Cognitive distortions are thoughts and attitudes that allow offenders to justify, rationalize, and minimize the impact of their deviant behavior. Cognitive distortions allow the adult sex offender and juveniles with sexual behavior problems to overcome prohibitions and progress from fantasy to behavior. These distorted thoughts provide the adult sex offender and juveniles with sexual behavior problems with an excuse to engage in deviant sexual behavior, and serve to reduce guilt and responsibility. Cognitive therapy strives to identify, assess, and modify cognitions that promote sexual deviance. Cognitive therapy is considered a vital component of treatment.

(3) Offense Cycle/Relapse Prevention. Current knowledge of deviant sexual behavior suggests that there is a cycle of behaviors, emotions, and cognitions that is identifiable and which precede deviant sexual behavior in a predictable manner. The ability to accurately identify these maladaptive behaviors is a primary goal for every adult sex offender and juvenile with sexual behavior problems in treatment. Autobiographies, sexual history polygraphs, offense reports, interviews and cognitive-behavioral chains are used to identify antecedents to offending. The ability to intervene can be enhanced by training primary partners and other support persons to recognize maladaptive behaviors and to encourage application of proper coping behaviors. In addition, treatment should include a formal multi-level relapse prevention plan.

(4) Victim Empathy. Although there is no clear evidence to suggest that all sex offenders can gain true empathy for victims of abuse, a universal goal of treatment is to learn to understand and value others. Highlighting the consequences of victimization helps sensitize the offender to the harm he or she has done. Empathy is comprised of cognitive and emotional aspects and both components may need to be addressed (ASTA Standard). The use of analogous experiences has been shown to be effective especially with juveniles. Secondary victims are relatives or other persons closely involved with the primary victim and client, who are severely impacted emotionally or physically by the trauma suffered by the victim.

(5) Biomedical Approaches. Intervention with psychopharmacological agents is useful in select cases. Antiandrogens such as depo-provera or Lupron act by reducing testosterone levels and may be helpful in controlling arousal and libido when these factors are undermining progress in therapy or increasing the risk of re-offending before significant progress can be made in the cognitive aspects of therapy. Antidepressants and medications targeting obsessive-compulsive symptoms are also useful in some individuals where those symptoms play a role in the overall psychodynamic picture. Likely candidates for biomedical intervention are those clients who are predatory, violent, have had prior treatment failures, and report an inability to control deviant sexual arousal. Use of these agents should never be the only method of treatment. Physical or chemical castration should be utilized only as an adjunct to treatment and not in lieu of treatment.

(6) Increasing Social Competence. Many adult sex offenders and juveniles with sexual behavior problems are poor problem-solvers, lack assertiveness, lack the ability to develop and sustain reciprocal friendships, and do not adequately manage anger or stress. They may lack the ability to develop and sustain reciprocal friendships. One goal of treatment is to improve the clients' ability to deal effectively with social situations and develop meaningful relationships with others.

(7) Improving Primary Relationships. Failure to develop and maintain a reciprocal, living relationship with an appropriate partner or healthy functional family may lead one to seek out alternative sexual outlets. With adults identifying specific sexual dysfunctions, sex therapy, and training in dating skills may be necessary to develop a functional lifestyle. Failure to involve the current partners or family members in therapy may lead to the same stresses that precipitated the sexual deviancy. With juveniles identifying sex education deficits and training in appropriate dating and relationship skills are essential to the development of a functional lifestyle.

(8) Couples/Family Therapy. To facilitate transition of the client's partner and or family into therapy a variety of treatment modalities are recommended. Individual, couple, family, and sibling therapy, non-offending spouses groups, and/or parents or legal guardians of victims' groups prepare the partner and family for the issues and methods involved in sex offender treatment. If an adult sex offender or juvenile is to eventually live in a home where survivors or children reside, a predetermined integration sequence should be followed which addresses role and boundary issues. This should include close supervision and a variety of safeguards for the protection of children.

(9) Support Systems. Involvement of close friends and family in therapy provides the offender with a milieu in which support is available. Part of the transition to follow-up is a reduction in group and in individual therapy. To compensate for this loss of support and surveillance, the support system should assist the adult sex offender and juvenile in avoiding and coping with antecedents to sexual deviance. The support system should include individuals from the adult sex offender and juvenile's daily life (for example: family, friends, co-workers, church members, and extended family).

(10) Adjunct Treatments: Substance abuse, anger management, stress management, social skills, or self-help groups shall only be used as adjuncts to a comprehensive treatment program in reducing the client's risk to re-offend.

(11) Co-morbid Diagnosis. In some adult sex offenders and juveniles with sexual behavior problems there are sufficient signs and symptoms to merit an additional diagnosis by DSM IV-TR criteria. These diagnoses can be anywhere in the entire spectrum of psychiatric disorder. The most common are alcohol abuse, substance abuse and affective disorders. Treating an alcohol or substance problem should not be assumed to make sex offender treatment unnecessary. Occasionally, the delusions and hallucinations of schizophrenia will be associated with the individual committing sexual offenses. The co-morbid diagnosis should be treated with the appropriate therapies concomitantly with the treatment for sex offending behavior except in the case of schizophrenia where the anti-psychotic therapy would take precedence.

(12) After-Care Treatment. A therapeutic regime that includes after-care treatment significantly increases the likelihood that gains made during treatment will be maintained. In order for new habits and skills to be reinforced and to monitor compliance with treatment

contracts, after-care treatment should involve periodic "follow up" sessions to reinforce and assess maintenance of positive gains made during treatment. This can be facilitated by involving the treatment group, supervision personnel, support system, the use of polygraphs, and phallometric assessment. Information from these sources may serve to deter future offenses or alert therapists to problems.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 458-7236

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SUBCHAPTER D. CODE OF PROFESSIONAL ETHICS

22 TAC §810.91, §810.92

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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22 TAC §810.91, §810.92

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.91. General.

Registrants are trained in dealing with the assessment and treatment of adult sex offenders and juveniles with sexual behavior problems. These registrants constitute a professional discipline, which has a membership committed to establishing and maintaining the highest level of professional standards related to the assessment and treatment of these clients. As such, they are conscious of their special skills and aware of their professional boundaries. They perform their professional duties with the highest level of integrity and appropriate confidentiality, within the scope of their statutory responsibilities. They will not hesitate to seek assistance from other professional disciplines when circumstances dictate a need to do so. They are committed to protect the public against and will not hesitate to expose unethical, incompetent, or dishonorable practices. In order to maintain the highest standard of service and consumer protection, they commit themselves to the following principles designed to earn the greatest level of public confidence.

§810.92. Code of Ethics.

(a) Professional Conduct.

(1) Each registrant will provide professional service to anyone, regardless of race, religion, sex, political affiliation, social or economic status, or choice of life style. A registrant will not allow personal feelings related to a clients alleged or actual crimes or behavior to interfere with professional judgment and objectivity. When a registrant cannot offer service to a client for any reason, he or she will make a proper referral. Registrants are encouraged to devote a portion of their time to work for which there is little or no financial return.

(2) Each registrant shall refrain from using his or her professional relationship, related to the assessment or treatment of a client, to further personal, religious, political or economic interests, other than customary professional fees.

(3) The proper conduct of each registrant is a personal matter to the same degree as it is with any other individual, except when such conduct compromises the fulfillment of professional responsibilities or reduces the public trust in this specialty area. Consequently, registrants are sensitive to predominant community standards and the potential impact that either conformity to, or deviation from these standards can have on the perception of their own performance, as well as that of their colleagues.

(4) Each registrant has an obligation to engage in continuing education and professional growth including active participation in meetings and affairs or relevant professional affiliations.

(5) Each registrant shall refrain from diagnosing, treating or advising on problems outside of the recognized boundaries of his/her competence.

(b) Client Relationships.

(1) Each registrant, shall offer dignified and reasonable support to a client, and shall not exaggerate the efficacy of his or her service.

(2) When engaged in private practice, each registrant shall recognize the importance pertaining to financial matters with clientele. Arrangements for payments are to be settled at the beginning of an assessment or a therapeutic relationship.

(3) Each registrant shall avoid dual relationships with clientele. These relationships may impair professional judgment or pose a risk of exploiting the client. Examples of dual relationships include, but are not limited to, the following: treatment of family members, close friends, employees, supervisors, supervisees, and relationships outside of treatment business or social.

(4) Sexual harassment or intimacy with clients is unethical. Sexual behavior between a registrant and a client constitutes a felony offense in Texas.

(5) A registrant shall not withdraw services to clients in a precipitous manner. Each member shall give careful consideration to all factors in the situation and take care to minimize possible adverse effects on the client.

(6) Each registrant who anticipates termination or disruption of service to clients shall notify the clients promptly and provide

for transfer, referral, or continuation of service in keeping with the clients needs and preferences.

(7) Each registrant who serves the clients of a colleague during a temporary absence or emergency shall serve those clients with the same consideration of that afforded any client.

(8) In their professional role, registrants shall avoid any action, which will violate or diminish the legal and civil rights of clients or others who may be affected by their actions.

(c) Confidentiality.

(1) Registrants will keep records on each client, storing them in such a way as to ensure their safety and confidentiality in accordance with the highest professional and legal standards including but not limited to HIPAA and the Texas Health and Safety Code, Chapter 611.

(2) Each registrant is responsible for informing clients of the exceptions to confidentiality. Clients should be informed of any circumstances which may trigger an exception to the agreed upon confidentiality.

(3) Registrants in criminal justice settings, or elsewhere, shall inform all parties with whom they are working of the level of confidentiality, which applies. They should clarify any circumstances, which would constitute exceptions to confidentiality, in advance of the service being rendered. Each registrant should make clear to the client any conflicts of interest or dual-client relationships, which affect his/her current relationship with a client.

(4) Written permission and informed consent shall be granted by the client before any data may be divulged to other parties.

(5) When responding to an inquiry for information and when a written release by the client is obtained, written and oral reports should present data germane to the purpose of the inquiry. Every effort should be made to avoid an undue invasion of privacy for the client or other related person.

(6) As noted above, information is not communicated to others without the written consent of the client unless the following circumstances occur.

(A) There exists a clear and immediate danger to a person from the client.

(B) There is an obligation to comply with specific statutes requiring reports of suspected abuse to authorities. Each registrant is responsible for becoming fully aware of all statutes, which pertain to the conduct of his or her professional practice.

(d) Assessments.

(1) Registrants shall every effort possible to promote the client's non-offending behavior while at the same time, acting in the best interest of the client, so long as others are not placed at identifiable risk. They guard against the misuse of assessment data. They respect their client's rights to know the results, the interpretations made, and the basis for the conclusions and recommendations drawn from such assessments. They endeavor to ensure that the assessment and reports they provide are used appropriately by others as well. Reports are written in such a way to communicate clearly to the recipient of the report.

(2) Unless the client agrees to an exception in advance, each registrant respects the right of the client to have a complete explanation, in language, which the client is able to understand, of the nature and purpose of the methodologies, and any foreseeable (side) effects of the assessment.

(3) Each registrant shall obtain voluntary informed consent, in written form, from a client prior to conducting a physiological assessment or engaging in treatment. In cases where a question exists regarding the appropriateness of administering a test to a particular client, the registrant shall seek expert guidance from a competent medical and/or psychological authority prior to testing.

(4) In court-ordered evaluations, the client should be informed of his rights as a client, including his rights of confidentiality.

(5) The responsible use of assessment measures is of paramount concern and a serious responsibility of each registrant. Assessments regarding a person's degree of sexual dangerousness, suitability for treatment, or other forensic referral questions shall not be determined solely by one assessment instrument. Rather, such data must be properly integrated within a comprehensive assessment, the components of which are determined by a person who has specific training and expertise in making such assessments.

(6) An assessment should not be used to confirm or deny whether an event or crime has taken place.

(7) In reporting assessment results, registrants indicate any reservations that might exist regarding validity or reliability because of the circumstances of the assessment or the absence of comparative norms for the person being tested. Each registrant endeavors to ensure that assessment results and interpretations are not misunderstood or misused by others. Proper qualifications will be made with regard to prediction and generalized ability of data issue, in order to not mislead the consumer of the report.

(8) Since it is not within the professional competence of registrants to offer conclusions on matters of law, unless they are trained to do so, they should resist pressure to offer such conclusions (for example: while it would be appropriate to address an issue regarding the probability of a client committing certain criminal acts within a certain period of time, it would be inappropriate to state that an individual is too dangerous to be released).

(9) Each registrant should be very cautious in offering predictions of criminal behavior for use in imprisoning or releasing individuals. If a registrant decided that it is appropriate to offer a prediction of criminal behavior, on the basis of a thorough evaluation in a given case, he or she should specify clearly:

(A) the acts being predicted;

(B) the estimated probability that these acts will occur during a given period of time; and

(C) the facts and data on which these predictive judgments are based.

(10) Each registrant should be thoroughly familiar with the assessment or treatment procedures and data used by another registrant before providing any public comment or testimony pertaining to the validity, reliability, or accuracy of such information.

(11) Each registrant shall safeguard sexual arousal assessment testing and treatment materials. Each registrant shall recognize the sensitivity of this material and use it only for the purpose for which it is intended in a controlled Phallometric laboratory assessment. Registrants shall not make such materials available to persons who lack proper training and credentials, or who would misinterpret or improperly use such stimulus materials.

(e) Professional Relationships.

(1) Each registrant shall refrain from knowingly offering treatment services to a client who is in treatment with another professional without initially consulting with the professionals involved.

(2) Each registrant shall act with proper regard for the needs, special competencies, and perspectives of not only colleagues who treat sex offenders but other professionals as well.

(3) Each registrant is encouraged to affiliate with professional groups, clinics, or agencies operating in the assessment and treatment of sex offenders. Similarly, interdisciplinary contact and cooperation is encouraged.

(f) Research and Publications.

(1) Each registrant is obligated to protect the welfare of his or her research subjects. Provisions of the human subjects experimental policy shall prevail as specified by the United States Department of Health, Education and Welfare guidelines.

(2) Each registrant shall carefully evaluate the ethical implications of possible research and has full responsibility to ensure that ethical practices are enforced in conducting such research.

(3) The practice of informed consent prevails. The research participant shall have full freedom to decline to participate in or withdraw from the research at any time without any prejudicial consequences.

(4) The research subject shall be protected from physical and mental discomfort, harm, and danger that may result from research procedures to the greatest degree possible.

(5) Publication credit is assigned to those who have contributed to a publication in proportion to their contribution, and in accordance with customary publication practices.

(g) Public Information and Advertising. All professional presentations to the public shall be governed by the following standards on public information and advertising.

(1) General Principles. The practice of assessment and treatment of the sex offender exists for the public welfare. Therefore, it is appropriate for registrants to inform the public of the availability of services. However, much needs to be done to educate the public as to the services available from qualified persons who engage in the assessment and treatment of sex offenders. Therefore, registrants have a responsibility to the public to engage in appropriate informational activities and avoid misrepresentation or misleading statements. The selection of a registrant by a prospective client should be made on an informed basis. Advice and recommendations of third parties, such as community corrections officers, attorneys, physicians, other professionals, relatives or friends, as well as responses to restrained publicity, may be helpful. Advertisements and public communications, whether in directories, announcement cards, newspapers or on radio or television, should be formulated to convey accurate information which is necessary to make an appropriate selection. Self-praising and testimonials should be avoided. Information that may be helpful in some situations would include the following:

(A) office information such as name, including a group name and names of professional associates, address, telephone number, credit card acceptability, languages spoken and written, and office hours;

(B) only earned degrees from an accredited college or university, state licensure and/or other certification, professional certification or affiliation;

(C) description of practice, including the statement that a practice is limited to the assessment or treatment of adult sex offenders and juveniles with sexual behavior problems (if appropriate); and

(D) professional fee information.

(2) The proper motivation for community publicity by members who are engaged in the assessment and treatment of adult sex offenders and juveniles with sexual behavior problems lies in the need to inform the public of the availability of competent professionals. The public benefit derived from advertising depends upon the usefulness and accuracy of the information provided to the community to which it is directed.

(3) The regulation of public statements by registrants is rooted in the public interest. Public statements through which a registrant seeks business by use of extravagant or brash statements or appeals to fears could mislead or harm the layperson. Furthermore, public communications that would produce unrealistic expectations in particular cases and would bring about a lack of confidence in the profession would be harmful to the community. The therapist-client relationship is personal and unique and should not be established as the result of pressures, deception or exploitation of the vulnerability of clients.

(4) The name under which a registrant conducts his or her practice may be a factor in the selection process. Use of a name or credential, which could mislead referral sources or lay persons is improper. Likewise, a registrant should not hold oneself out as being a partner or associate of any agency or firm if he is, in fact, not acting in that capacity (for example: a person engaged in private practice who is also employed at a state hospital should make it clear to a prospective client in private practice that he is not acting on behalf of a state hospital).

(5) In order to avoid the possibility of misleading persons with whom he or she deals, a registrant should be scrupulous in the representation of his or her professional background, training and status. Each registrant must indicate, if it is accurate, any limitations in his or her practice (for example: an ASOTP should specify that he/she must operate under the supervision of a RSOTP).

(6) Registrants shall not represent their affiliation with any organization or agency in a manner, which falsely implies sponsorship or certification by that organization.

(7) Registrants shall not knowingly make a representation about his or her ability, background, or experience, or about that of a partner or associate, or about a fee or any other aspect of a proposed professional engagement that is false, fraudulent, misleading, or deceptive. A false, fraudulent, misleading, or deceptive statement or claim is defined as a statement or claim which:

(A) contains a material misrepresentation of fact;

(B) omits any material or statement of fact which is necessary to make the statement, in light of all circumstances, not misleading; or

(C) is intended or likely to create an unjustified expectation concerning the registrant, or services.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. GENERAL PROVISIONS

22 TAC §810.121, §810.122

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Walter J. Meyers, M.D.
Chairperson
Council on Sex Offender Treatment
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For further information, please call: (512) 458-7236

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22 TAC §810.121, §810.122

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.121. Introduction.

(a) General. The provisions of Subchapters E-J of this chapter govern the procedures relating to the civil commitment of sexually violent predators in the State of Texas and the development of a case management system, which provides appropriate and necessary treatment and supervision.

(b) Construction. These sections cover definitions, criteria for case managers, treatment providers, and biennial examination experts; guidelines for the supervised housing of sexually violent predators; outpatient treatment plans and standards of care; civil commitment requirements, supervision and tracking services; the exchange and release of information relating to sexually violent predators; commitment review procedures; petitions for release; and immunity from liability for good faith conduct.

(c) History. The legislature has determined that a small but extremely dangerous group of sexually violent predators were being released from prison that had a behavioral abnormality that was not amenable to traditional mental illness treatment modalities and were likely to engage in repeated predatory acts of sexual violence. The legislature determined that the existing involuntary commitment provisions of Vernon's Ann. Tex. Const. Art. 1, §15-a, were inadequate to address the risk to society of repeated predatory behavior of the sexually violent predator. The legislature further determined that treatment modalities for sexually violent predators were different from traditional psychotherapy modalities. The legislature concluded that a civil commitment standard for the long-term comprehensive and offense specific supervision and treatment of sexually violent predators was necessary for the protection of the citizens of the State of Texas (Health and Safety Code, Chapter 841).

§810.122. Definitions.

The following words and terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise.

(1) Act--Health and Safety Code, Chapter 841. Civil Commitment of Sexually Violent Predators.

(2) Behavioral abnormality--A congenital or acquired condition that, by affecting a person's emotional or volitional capacity, predisposes the person to commit a sexually violent offense, to the extent that the person becomes a menace to the health and safety of another person.

(3) Biennial examination expert--A person or persons employed by or under contract with the council to conduct a biennial examination to assess any change in the behavioral abnormality for a person committed under the Act, §841.081.

(4) Child safety zone--An area as defined in Code of Criminal Procedure, Art. 42.12, §13B and Health and Safety Code, §841.134.

(5) Civil commitment--The civil commitment of a person adjudged to be a sexually violent predator and committed to the outpatient sexual violent predator treatment program (OSVPTP).

(6) Civil commitment case manager--A person employed by or under contract with the council to perform duties related to the supervision, coordination and monitoring of the person committed to the outpatient treatment and supervision program.

(7) Civil commitment treatment provider--A person under contract with the council to conduct assessments, provide intensive treatment, conduct treatment planning, and to assist the Civil Commitment Case Manager in supervising the sexually violent predator.

(8) Council--The Council on Sex Offender Treatment.

(9) Global Positioning Satellite (GPS) Tracking--Technology that incorporates global positioning tracking and electronic radio frequency. GPS allows the person's location to be monitored 24 hours per day, 7 days per week.

(10) Interagency Case Management Team--All professionals involved in the treatment, assessment, supervision, monitoring, residential housing of the client, or other approved professionals. The case manager is the chairperson of the team.

(11) Multidisciplinary Team--Composed of members of the Council on Sex Offender Treatment (2), Texas Department of Criminal Justice (1), Texas Department of Criminal Justice-Victim Service Division (1), Texas Department Public Safety (1), and Texas Department of Mental Health and Mental Retardation or its successor agency (2). The team assesses whether a person is a repeat sexually violent offender and whether the person is likely to commit a sexually violent offense after release or discharge, gives notice to the Texas Department of Criminal Justice or the Texas Department of Mental Health and Mental Retardation, and recommends the assessment of the person for a behavioral abnormality (Act, §841.022).

(12) Penile Plethysmograph--A diagnostic method to assess sexual arousal by measuring the blood flow (tumescence) to the penis during the presentation of sexual stimuli in a laboratory setting. The plethysmograph provides the identification of clients' arousal in response to sexual stimuli (audio/visual) and the evaluation of treatment efficacy.

(13) Clinical polygraph examination-The employment of any instrumentation complying with the required minimum standards

of the Texas Polygraph Examiner's Act. Polygraphs measure the emotional arousal that is caused by fear and anxiety. The autonomic nervous system responds to arousal with physiological reactions such as increased heart rate, depth of respiration, and sweat gland activity. There are four types of polygraphs including:

(A) Disclosure Polygraph-addresses the offense of conviction in conjunction with the official version;

(B) Sexual History Polygraph-addresses the complete sexual history of the client up to the instant offense;

(C) Maintenance Polygraph-addresses compliance with conditions of supervision and treatment; and

(D) Monitoring Polygraph-addresses if the client has committed a "new" sexual offense.

(14) Polygraph examiner--A licensed polygraph examiner who shall adhere to the Joint Polygraph Committee on Offender Testing (JPCOT) for polygraphing adult sex offenders and juveniles with sexual behavior problems.

(15) Predatory act--An act that is committed for the purpose of victimization and that is directed toward:

(A) a stranger;

(B) a person of casual acquaintance with whom no substantial relationship exists; or

(C) a person with whom a relationship has been established or promoted for the purpose of victimization.

(16) Repeat sexual offender--A person is a repeat sexually violent offender for the purposes of this chapter if the person is convicted of more than one sexually violent offense and a sentence is imposed for at least one of the offenses or if:

(A) the person:

(i) is convicted of a sexually violent offense, regardless of whether the sentence for the offense was ever imposed or whether the sentence was probated and the person was subsequently discharged from community supervision;

(ii) enters a plea of guilty or nolo contendere to a sexually violent offense in return for a grant of deferred adjudication;

(iii) is adjudged not guilty by reason of insanity of a sexually violent offense; or

(iv) is adjudicated by a juvenile court as having engaged in delinquent conduct constituting a sexually violent offense and is committed to the Texas Youth Commission under Family Code, §54.04(d)(3) or (m); and

(B) after the date on which under Health and Safety Code, §841.003(b) Subdivision (1), the person is convicted, receives a grant of deferred adjudication, is adjudged not guilty by reason of insanity, or is adjudicated by a juvenile court as having engaged in delinquent conduct, the person commits a sexually violent offense for which the person:

(i) is convicted, but only if the sentence for the offense is imposed; or

(ii) is adjudged not guilty by reason of insanity.

(17) Residential facility--A community residential facility, or halfway house, located in the State of Texas, and under contract with the council or the Texas Department of Criminal Justice.

(18) Sexually violent offense:

(A) an offense under the Penal Code, §§21.11(a)(1), 22.011, or 22.021;

(B) an offense under the Penal Code, §30.04(a)(4), if the defendant committed the offense with the intent to violate or abuse the victim sexually;

(C) an offense under the Penal Code, §30.02, if the offense is punishable under subsection (d) of that section and the defendant committed the offense with the intent to commit an offense listed in subparagraphs (A) or (B) of this paragraph;

(D) an attempt, conspiracy, or solicitation, as defined by the Penal Code, Chapter 15, to commit an offense listed in subparagraphs (A), (B) or (C) of this paragraph;

(E) an offense under prior state law that contains elements substantially similar to the elements of an offense listed in subparagraphs (A), (B), (C) or (D) of this paragraph; or

(F) an offense under the law of another state, federal law, or the Uniform Code of Military Justice that contains elements substantially similar to the elements of an offense listed in subparagraphs (A), (B), (C), or (D) of this paragraph.

(19) Sexually violent predator (SVP)--A person as defined in the Health and Safety Code, §841.003. A person is a sexually violent predator for the purpose of this chapter if the person: is a repeat sexually violent offender; and suffers from a behavioral abnormality that makes the person likely to engage in a predatory act of sexual violence; is convicted of more than one sexually violent offense and a sentence is imposed for at least one of the offenses.

(20) Supervision, Treatment, and GPS Requirements--Are the requirements whereby a person agrees to participate and comply with the conditions of the Outpatient Sexually Violent Predator Treatment Program (OSVPTP).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER F. CIVIL COMMITMENT

22 TAC §810.151 - 810.153

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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22 TAC §§810.151 - 810.153

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.152. Civil Commitment of Sexually Violent Predators.

In the event that a judge or jury determines that a person is a sexually violent predator (SVP), the person shall be committed by the judge to the Outpatient Sexually Violent Predator Treatment Program (OSVPTP) in accordance with a treatment and supervision plan approved by the council. Upon making a determination that a person is a SVP, the committing judge shall provide the council and the person with a copy of the civil commitment requirements for the person committed. The OSVPTP must begin on the person's release from a secure correctional facility or discharge from a state hospital and must continue until the person's behavioral abnormality has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence. A case manager who has been approved by the council shall coordinate the OSVPTP. The council shall provide the case manager with all available documentation relating to the client including but not limited to a copy of the civil commitment requirements imposed upon the person by the committing judge.

§810.153. Outpatient Treatment and Supervision Program.

The council shall contract for the provision of an OSVPTP, which utilizes cognitive behavioral sex offender treatment and intensive supervision to attain the goal of no more victims. The OSVPTP containment model is composed of the following elements treatment orientation, assessments, and evaluations, global positioning tracking services, polygraph examinations, medication, transportation, penile plethysmograph, supervision, treatment, residential housing (if appropriate), and auditing services.

(1) Housing. The council shall provide for any necessary supervised or residential housing, including but not limited to, existing community residential facilities, or halfway houses currently under contract with the council or the Texas Department of Criminal Justice (TDCJ) and private entities, or other similar residential facilities as warranted. The supervised housing shall be approved by the council and shall be in locations around the State where the Department of Public Safety (DPS) maintains sufficient personnel who are properly trained in utilizing all forms of tracking services.

(2) Orientation. A person civilly committed by a judge, shall receive an orientation session from the assigned treatment provider involving the OSVPTP. The council shall establish policies and procedures for informing the person of his rights, obligations, and responsibilities under the OSVPTP. A person civilly committed to the OSVPTP must sign all forms, releases and consent documents approved by the council, including but not limited to, the Treatment, Supervision, and GPS requirements which relate to said OSVPTP, and the person must agree to strictly adhere to the terms and conditions of said requirements and other documents as required by the Court. A person, who signs the requirements and adheres to its terms and conditions, is allowed to begin the OSVPTP. If the person fails to sign the documents, he is not permitted to begin the OSVPTP and will be subject to all legal sanctions available under the Act.

(3) Evaluation. The initial stage of the OSVPTP shall begin with a formal assessment of the SVP. The initial assessment shall involve two components. First, the treatment provider shall review and validate the formal risk assessment. Second, the treatment provider shall conduct an assessment for the purpose of identifying individual needs, which must be addressed during the OSVPTP. The individual needs as identified by the treatment provider shall be included in the person's individual treatment plan.

(4) Global Positioning Tracking Services. The council shall enter into an Interagency Agreement with the DPS, which will provide the technology and expertise to track sexually violent predators during their commitment to the OSVPTP. The primary focus of intensive tracking services is to ensure public safety, the highest level of client accountability, compliance with adhering to a daily activity schedule and to the requirements of the OSVPTP. Such services shall include but not be limited to monitoring global position tracking, electronic monitoring, and surveillance. All SVPs shall begin an intensive monitoring system once a judge civilly commits the person for outpatient treatment and supervision or is released from a security facility. The person shall be on the intensive global positioning tracking until the person's behavioral abnormality has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence.

(5) Polygraph Services. The person is mandated by the order of commitment to submit to polygraph testing. The treatment plan shall consist of clinical polygraph exams specific to sex offenders, including instant offense, sexual history, maintenance and monitoring exams. The council shall only approve treatment plans, which utilize licensed polygraph examiner who shall agree to adhere to the Joint Polygraph Committee guidelines for polygraphing sex offenders.

(6) Medication. Medication may include anti-psychotic, anti-depressant, anti-anxiety, anti-obsessional, anti-androgenic and/or equivalent chemotherapy.

(7) Penile Plethysmograph. The person is mandated by the order of commitment to submit to plethysmograph testing. The plethysmograph shall be used to identify the clients who manifest excessive deviant arousal in response to stimuli depicting sexual abuse, discernment of lack of arousal to stimuli of consenting sex, minimization of distortions evident in self-report level of arousal, evaluation of treatment efficacy, and enhancement of certain forms of behavioral treatment.

(8) Supervision. The council shall establish employment policies and procedures for the hiring of a contracted case manager who will be responsible for the coordination of the treatment and supervision of the person civilly committed, and monitoring compliance with the treatment and supervision requirements for that person. The case manager shall be required to:

(A) conduct face to face contact at the office, residence, and field visits to monitor the SVP;

(B) serve as a liaison with the sex offender therapist, global positioning tracking services; polygraph examiner, District Attorneys, residential staff, parole officer, employer, and all other professionals involved in the person's life;

(C) shall report any violation to the council within 24 hours;

(D) shall ensure the residential plan is congruent with the child safety zone laws;

(E) shall ensure the person registers with the Texas Department of Public Safety every days;

(F) shall make referrals for alcohol and drug testing;

(G) adjust the person's supervision according to the risk assessment;

(H) shall make timely recommendations to the judge on whether to allow the committed person to change residence or to leave the state and on any other appropriate matters shall inform the person annually of their right to file for unauthorized release;

(I) shall submit the biennial report to the Judge;

(J) shall coordinate transportation services for the person; and

(K) shall abide by the Case Manager Code of Ethics.

(9) Sex Offender Treatment. The council shall approve and contract for the provision of treatment, which is based on a cognitive behavioral model with the focus of the treatment being holistic. The OSVPTP shall include, but not be limited to, sex offender specific group and individual therapy; social skills training, medicine, and if deemed warranted by the treatment provider, substance abuse counseling or traditional mental health treatment. The treatment plan shall be composed of standard tasks, which all persons must complete prior to moving to the next stage. In addition, individual goals shall be established based upon evaluation data. A treatment plan shall include the monitoring of the person with a polygraph and penile plethysmograph. The council shall establish guidelines and policies and procedures for the hiring of contracted treatment providers who will be responsible for developing and implementing an individual treatment plan approved by the council. All treatment plans and guidelines for standards of care are subject to the approval of the council prior to implementation.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER G. CIVIL COMMITMENT CASE MANAGER AND TREATMENT PROVIDER DUTIES AND RESPONSIBILITIES

22 TAC §§810.181 - 810.183

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

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22 TAC §§810.181 - 810.183

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.181. General.

The Council on Sex Offender Treatment is responsible but not limited to providing appropriate and necessary treatment, supervision, residential services, and transportation through a case management system, which requires the contracting for these services.

§810.182. Civil Commitment Case Manager.

The council shall approve and contract for the services of a person to perform duties related to outpatient treatment and supervision of a person civilly committed to the Outpatient Sexually Violent Predator Treatment Program (OSVPTP). The council shall establish employment policies and procedures, which set forth duties and responsibilities, minimum qualifications, knowledge, skills, and abilities required of a person serving in such capacity. The case manager shall report directly to the council through its Executive Director or designee; provide supervision to the SVP; ensure community safety by monitoring the SVP; communicate with law enforcement, treatment providers, prosecutors, and the judge having jurisdiction over the person's commitment; coordinate outpatient treatment for the SVP; periodically reviews assessments to determine the success of outpatient treatment and supervision; train residential housing staff; provide periodic reports to the council through its Executive Director or designee and to the judge having jurisdiction over the person's commitment; and make recommendations to the judge having jurisdiction over the person's commitment as to whether or not to allow the committed person to change residence , or any other appropriate matters relating to the person's civil commitment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER H. CIVIL COMMITMENT REVIEW

22 TAC §810.211

The repeal is adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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22 TAC §810.211

The new section is adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.211. Biennial Examination.

(a) A person who is civilly committed under the Act, §841.081, shall receive a biennial examination conducted by an expert. The council shall approve and contract for the services of an expert who will conduct a biennial examination of the person civilly committed as a sexually violent predator. The expert shall not be the same expert who conducted the initial examination of the person for civil commitment purposes. The expert shall produce a written report within 90 days from the date of referral or earlier if required by the court, which shall include the following:

(1) the client's name, identification number, and date of examination;

(2) client's version and official version of the instant offense;

(3) client's level of denial of the instant offense and denial of deviant arousal or intent;

(4) history of assessment utilized, method and description of testing, and analysis of test data;

(5) a background summary of the client's history regarding sexual history, social history, birth/development, family marital, education, employment, substance abuse, anger, suicide, psychiatric, and current psychiatric symptoms;

(6) current mental status based on clinical observation and diagnosis of mental illness as per the current Diagnostic and Statistical Manual;

(7) a treatment or supervision history and a description of the client's history in an outpatient program;

(8) a determination if the client's behavioral abnormality has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence;

(9) the examiner's recommendation regarding the client's need for civil commitment; and

(10) expert's signature and title.

(b) The report shall also include a consideration of whether to modify a requirement imposed on the person under the Act, and whether to release the person from all of the requirements imposed on the person under the Act. The case manager shall provide a report of the client's compliance or non-compliance with treatment and supervision to the judge having jurisdiction over the person's commitment, and to the council through its Executive Director or designee. The council shall establish employment guidelines and policies setting forth duties and responsibilities, minimum qualifications, knowledge, skills, and the abilities of a person serving as a biennial examination expert. The expert shall not be the same expert who conducted the initial examination of the person for civil commitment purposes.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER I. PETITION FOR RELEASE

22 TAC §810.241, §810.242

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

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22 TAC §810.241, §810.242

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt

rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.242. Unauthorized Petition for Release.

Upon a person's commitment to the OSVPTP and on an annual basis thereafter, the case manager shall provide the committed person with written notice of the committed person's right to file a petition for release which has not been authorized by the case manager. The case manager shall provide a copy of the written notice to the council through its Executive Director or designee.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER J. MISCELLANEOUS PROVISIONS

22 TAC §810.271, §810.272

The repeals are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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22 TAC §§810.271 - 810.275

The new sections are adopted under Texas Occupations Code, §110.158, which provides the council with the authority to adopt rules consistent with the chapter and under Texas Health and Safety Code §841.141, which provides the council with the authority to adopt rules consistent with the purposes of the chapter.

§810.275. Immunity.

Pursuant to the Act, §841.147, the following persons are immune from liability for good faith conduct under this chapter: an employee, member, or officer of the Texas Department of Criminal Justice, the Texas Department of Mental Health and Mental Retardation, Department of State Health Services, or the council, a member of the multidisciplinary team established under §841.022 an employee of the division of the prison prosecution unit charged with initiating and pursuing civil commitment proceedings under this chapter; and a person providing, or contracting, appointed, or volunteering to perform a tracking service or another service under this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 19. AGENTS' LICENSING

SUBCHAPTER H. LICENSING OF PUBLIC INSURANCE ADJUSTERS

28 TAC §19.713

The Commissioner of Insurance adopts new §19.713 concerning Public Insurance Adjusters Rules of Professional Conduct and Ethics. The new section is adopted without changes to the proposed text as published in the July 2, 2004 issue of the *Texas Register* (29 TexReg 6223) and will not be republished.

This section is necessary to implement Texas Insurance Code Article 21.07-5, §18(1), enacted as part of Senate Bill 127, 78th Legislature Regular Session. New §19.713 concisely states certain significant legal and ethical requirements for public insurance adjusters' professional conduct. Thus, §19.713 will instruct public insurance adjusters regarding their required professional ethical behavior.

The additional requirements contained in §19.713 will enhance consumer protection efforts by providing a reference point for consumers and others regarding public insurance adjusters' professional conduct. The requirements will serve as a tool for directing public insurance adjusters' interactions with the public and will facilitate the continued improvement of the professional ethical conduct of public insurance adjusters.

Legal and ethical requirements that regulate public insurance adjusters' professional conduct are found in existing laws, such as laws relating to matters of licensure, as well as those defining specific obligations of public insurance adjusters. Accordingly, although §19.713 contains certain requirements for the legal and ethical professional conduct of public insurance adjusters, it does not contain an exhaustive list of the legal or ethical requirements that govern the actions of public insurance adjusters.

Adopted §19.713 provides public insurance adjusters with a statement of certain legal and ethical requirements that are of prime importance in the conduct of their business. It also provides that the list of legal and ethical requirements is not exhaustive.

Specifically, §19.713 states that the requirements for public insurance adjusters include: conducting their business "fairly and in good faith without detriment to the public," refraining from improper solicitation, refraining from using misrepresentations in the conduct of their business, charging appropriate fees and commissions, completing continuing education, possessing adequate knowledge and experience to handle their work appropriately, not engaging in the unauthorized practice of law, not engaging in activities that may be construed as presenting a conflict of interest or obtaining a financial interest in salvaged property that is the subject of a claim, using only advertisements that do not violate the Insurance Code, and using contract forms that are approved by the commissioner.

Comment: A commenter expressed support for §19.713, but also stated that other jurisdictions have approved more specific regulations concerning ethical conduct of public adjusters, and emphasized that the department should not be precluded from being more specific in future regulations if necessary.

Agency Response: The department appreciates the commenter's support. Section 19.713 does not contain all of the requirements by which public insurance adjusters must abide, but provides standards of fair and reasonable conduct for public insurance adjusters to follow within their industry. Other statutory provisions, such as licensure, have overlapping requirements regarding the conduct of public insurance adjusters. The department will monitor the effect of the rule and, if necessary, propose expansion to address issues that might arise in the future.

For: Office of Public Insurance Counsel.

This section is adopted under Insurance Code Article 21.07-5 and §36.001. Article 21.07-5, §18(1) directs the commissioner to adopt a code of ethics for public insurance adjusters that governs their conduct and sets forth various requirements for public insurance adjusters. Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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General Counsel and Chief Clerk
Texas Department of Insurance
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PART 2. TEXAS WORKERS' COMPENSATION COMMISSION

CHAPTER 122. COMPENSATION PROCEDURE--CLAIMANTS

The Texas Workers' Compensation Commission (commission) adopts amendments to §122.2, concerning Injured Employee's Claim for Compensation, and §122.100, concerning Claim for Death Benefits, with no changes to the proposed text published in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6225).

As required by the Government Code §2001.033(1), the commission's reasoned justification for these rules are set out in this order which includes the preamble, which in turn includes the rules. This preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rules, and the reasons why the commission disagrees with some of the comments and recommendations.

The amendments to §122.2 are to allow submission of an injured employee's claim for compensation in an electronic format and delete the requirement for the injured employee's signature. The amendments to §122.100 are to allow submission of a claim for death benefits in an electronic format and provide the manner of filing subsequent filings of all additional evidence that establishes that the claimant is a legal beneficiary. The electronic filing options provided by the amendments are part of an overriding goal of the commission, in its Business Process Improvement (BPI) project, to improve and streamline agency processes and applications through the use of advanced technology and tools, as appropriate, to increase agency effectiveness, efficiency, and accountability.

Currently, §122.2 specifies the form that must be used by injured employees to file a claim for compensation. In order to achieve standardization with existing rule 102.5, General Rules for Written Communication to and from the Commission, which allows electronic submission of information, the commission amends subsection (c) to allow reporting of a claim for compensation to the commission either on paper or via electronic transmission, in the form, format, and manner prescribed by the commission.

The commission amends subsection (c)(6) by adding language to clarify that, if the injury claimed is an occupational disease, the claim must include the name and location of the employer at the time of the last injurious exposure to the hazards of the occupational disease. As a result of this clarification, the commission deletes subsection (d) because it is redundant of subsection (c)(6) as amended.

The commission deletes current subsection (e), which requires the prescribed form TWCC-41 or other written claim for compensation must be signed by the person filing it and change the reference to "no later than" one year to "within" one year. As a result of deleting subsections (d) and (e), the commission re-designates subsection (f) as subsection (d).

Currently, §122.100 specifies the form that must be used by claimants to file a claim for death benefits. In order to achieve standardization with existing rule 102.5, General Rules for Written Communication to and from the Commission, which allows electronic submission of information, the commission amends subsection (b) to allow reporting of a claim for death benefits to the commission either on paper or via electronic transmission, in the form, format, and manner prescribed by the commission.

The commission also amends subsection (c) to clarify that a claimant is required to submit not only a copy of the deceased

employee's death certificate but also any additional evidence that establishes that the claimant is a legal beneficiary of the deceased employee. Paragraphs (c)(1) and (2) are added to address how the additional evidence regarding legal beneficiary status should be submitted depending on whether the claim is filed on paper or electronically. The commission also amends subsection (c) by deleting certain unnecessary language.

The following groups or associations provided comments regarding the proposed amendments:

Insurance Council of Texas supported the commission's adoption of amended sections 122.2 and 122.100.

Texas Mutual Insurance Company opposed adoption of the proposed amendments to §§122.100(b) and (c).

Summaries of the comments and commission responses are as follows:

§122.2

COMMENT: Commenter supports the adoption of the proposed amendments.

RESPONSE: The Commission agrees.

§122.100

COMMENT: Commenter supports the adoption of the proposed amendments.

RESPONSE: The Commission agrees.

COMMENT: Commenter recommends striking the proposed amendments to §§122.100(b) and (c) "that would require beneficiary to submit the claim for death benefits and attachments to the commission," asserting that the beneficiary information should be provided directly to the carrier that is responsible for determining beneficiary eligibility and benefits, rather than to the commission. Commenter observed that a "claim for beneficiary benefits is a transaction between the individual and the appropriate carrier, and there does not appear to be a need for the commission to have a role in this transaction."

RESPONSE: The commission disagrees. The amendments to §§122.100(b) and (c) do not impose a new requirement for a beneficiary to submit a claim for death benefits directly to the commission. The rule currently requires this. The commission also disagrees with commenter's assertion that the commission should not have a role in transactions associated with claims for death benefits. On the contrary, Tex. Labor Code §409.007 explicitly requires a claim for death benefits to be filed with the commission.

COMMENT: Commenter asserts that certain commission rules (§§132.3, 132.4, and 132.5) require beneficiaries claiming death benefits to send to the carrier certain documentation establishing their legal beneficiary status, and this requirement cannot be satisfied by the commission's providing such records to the carrier in lieu of this communication.

RESPONSE: The commission disagrees with commenter's interpretation of the proposed amendments as allowing or requiring the commission to provide records to a carrier in lieu of the communication requirements of §§132.3, 132.4, and 132.5 of the commission's rules. Furthermore, the commission disagrees that the amendments eliminate or otherwise modify the requirements of §§132.3, 132.4, 132.5, or any other commission rule. As stated above, the amendments simply allow the claim to be filed in an electronic format and provide the manner of filing additional evidence that establishes that the claimant is a legal beneficiary.

SUBCHAPTER A. CLAIMS PROCEDURE FOR INJURED EMPLOYEES

28 TAC §122.2

The amendments are adopted pursuant to Texas Labor Code §402.042, which authorizes the Executive Director to enter orders as authorized by the statute as well as to prescribe the form, manner and procedure for transmission of information to the commission; Texas Labor Code §402.061, which authorizes the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; Texas Labor Code §409.003, which sets forth the requirements for an injured employee or person acting on their behalf to file a claim for compensation with the commission; and Texas Labor Code §409.007, which sets forth the requirements for a legal beneficiary or person acting on their behalf to file a claim for death benefits with the commission.

The amended rules are adopted under Texas Labor Code §§402.042, 402.061, 409.003, and 409.007.

The previously cited sections of the Texas Labor Code are affected by this rule action. No other code, statute, or article is affected by this rule action.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405319
Susan Cory
General Counsel
Texas Workers' Compensation Commission
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Proposal publication date: July 2, 2004
For further information, please call: (512) 804-4287

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SUBCHAPTER B. CLAIMS PROCEDURE FOR BENEFICIARIES OF INJURED EMPLOYEES

28 TAC §122.100

The amendments are adopted pursuant to Texas Labor Code §402.042, which authorizes the Executive Director to enter orders as authorized by the statute as well as to prescribe the form, manner and procedure for transmission of information to the commission; Texas Labor Code §402.061, which authorizes the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; Texas Labor Code §409.003, which sets forth the requirements for an injured employee or person acting on their behalf to file a claim for compensation with the commission; and Texas Labor Code §409.007, which sets forth the requirements for a legal beneficiary or person acting on their behalf to file a claim for death benefits with the commission.

The amended rules are adopted under Texas Labor Code §§402.042, 402.061, 409.003, and 409.007.

The previously cited sections of the Texas Labor Code are affected by this rule action. No other code, statute, or article is affected by this rule action.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

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Susan Cory
General Counsel
Texas Workers' Compensation Commission
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CHAPTER 133. GENERAL MEDICAL PROVISIONS

SUBCHAPTER D. DISPUTE AND AUDIT OF BILLS BY INSURANCE CARRIERS

28 TAC §133.308

The Texas Workers' Compensation Commission (the commission) adopts amended §133.308 with one change to the proposed text published in the March 5, 2004, issue of the *Texas Register*(29 TexReg 2186).

As required by the Government Code §2001.033(l), the commission's reasoned justification for this rule is set out in this order, which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support or opposition to adoption of the rule, and the reasons why the commission disagrees with some of the comments and proposals.

No changes were made to the proposed rule amendment in response to public comment received in writing and at a public hearing held on April 14, 2004. However, a change was made to the effective date of the proposed rule amendment in response to commission staff recommendations. This change is described in the Description of the Adopted Amendment.

The adopted amendment to §133.308, Medical Dispute Resolution By Independent Review Organizations, directs medical disputes regarding retrospective medical necessity of medical services costing less than the cost of a review by an Independent Review Organization (IRO) to newly adopted §133.309, Alternate Medical Necessity Dispute Resolution by Case Review Doctor (AMDR).

More specifically, new §133.309 is the exclusive process for retrospective review of medical necessity disputes where the sum of disputed billed charges is less than the tier one IRO fee.

New §133.309 is concurrently being adopted pursuant to the statutory provisions in Texas Labor Code §413.031. House Bill 3168, adopted during the 2003 Texas Legislative Session, amended §413.031 to add a new subsection (m) regarding new authority for commission medical dispute resolution. This new statutory provision states the commission by rule may prescribe an alternate dispute resolution process to resolve disputes regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization.

Rule 133.308 will continue to be the process for retrospective review of medical necessity disputes where the sum of disputed billed charges is equal to or greater than the tier one IRO fee. The adopted amendment to §133.308 establishes October 1, 2004 as the effective date for dispute requests filed in accordance with the adopted new rule and this amended rule.

There is a change to amended subsection (a) of the rule as proposed. Amended subsection (a) establishes applicability. The adopted amendment states that when applicable, retrospective medical necessity disputes shall be governed by the provisions of §133.309 of this title (relating to Alternate Medical Necessity Dispute Resolution by Case Review Doctor), effective for dispute resolution requests filed on or after October 1, 2004. This effective date was changed from August 1, 2004 in the proposal to allow for development of necessary infrastructure and training to implement newly adopted §133.309 of this title.

The commission's Medical Advisor reviewed and made recommendations regarding this adopted rule.

Comment generally supporting amended §133.308 as proposed was received from PMSI.

Comment generally opposing amended §133.308 as proposed was received from the Insurance Council of Texas.

Comment neither generally supporting nor opposing amended §133.308 as proposed, but suggesting a change was received from the Texas Association of School Boards.

Summaries of the comments and commission responses are as follows:

COMMENT: Commenter recommended the following language be added to subsection (e), "TWCC Compliance & Practices will not process intake of medical disputes where the health care provider has not met criteria for (1) and (2) in subsection (c) above."

RESPONSE: The commission disagrees with the recommendation to add the suggested language to subsection (e). The recommendation lies outside the scope and purpose of the proposed amendment as it pertains to provisions of this section related to reviews by independent review organizations and not the AMDR process. This subsection of the rule is not currently under consideration for amendment.

COMMENT: Commenter recommended to amend the preauthorization rule to expand the list to include therapy services that are commonly disputed.

RESPONSE: The commission disagrees as this recommendation is beyond the scope and purpose of the proposed amendment to §133.308.

COMMENT: Commenter recommended that language be added explaining that the Medical Dispute Resolution (MDR) process is not intended to be used to retrospectively review for medical necessity services that were previously preauthorized or voluntarily certified. Commenter recommended the withdrawal of the proposed amendment and further recommended the rule be amended to add a new tier for Independent Review Organization (IRO) reviews of retrospective medical necessity disputes where the amount in dispute is less than the tier one fee for an IRO

review. Commenter included recommended language for corresponding amendments to subsections (f), (h), and (r) that addresses limits on medical documentation submissions, prohibits consideration of bills from multiple providers, consolidates multiple disputes from the same time period, and prohibits injured employees from filing disputes on behalf of providers.

RESPONSE: The commission disagrees that language needs to be added to explain that the MDR process is not intended for the review of services that are retrospectively denied for medical necessity after previously being preauthorized or voluntarily certified. The commission clarifies that if health care services have been preauthorized or voluntarily certified, and a carrier denies the services as not medically necessary, the carrier is in violation of §133.301(a) of this title, regarding Retrospective Review of Medical Bills. The commission disagrees with the recommendations to withdraw the proposed amendment and to add a new tier for IRO reviews. HB-3168, allows the commission to develop by rule an alternate medical dispute resolution process for retrospective medical necessity disputes costing less than the cost of an IRO review. The intent of the newly adopted §133.309, regarding Alternate Medical Necessity Dispute Resolution by Case Review Doctor, is to create an expedited low dollar dispute process for a nominal fee. In evaluating the use of IROs for the AMDR process, the commission determined that utilizing doctors on the commission's Approved Doctor List (ADL) would be more cost effective and would result in a pool of case reviewers willing to perform a review for the nominal fee.

COMMENT: Commenter stated that the proposed amendment will benefit not only the treating doctors but also other health care providers who will now be able to seek resolution on billing matters that are of a smaller monetary amount. Commenter stated that a lower IRO fee is a good idea but questioned who will police outcomes so that monies due are received.

RESPONSE: The commission agrees that the newly adopted AMDR rule and process will benefit system participants, especially for services with low dollar disputed amounts. The commission clarifies that an AMDR case review fee is not an IRO fee, as AMDR disputes will be reviewed by doctors selected from the commission's ADL. The outcomes, including monetary reimbursement in the newly adopted AMDR rule and process, are subject to enforcement by the commission's Compliance and Practices Division.

The amended rule is adopted under the following statutes: Texas Labor Code §402.061, which authorizes the commission to adopt rules necessary to administer the Act; Texas Labor Code §401.011, which provides general definitions used under the Act; Texas Labor Code §401.024, which provides the commission with authority to require use of facsimile or other electronic means to transmit information in the system; Texas Labor Code §402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form, manner, and procedure for transmission of information to the commission; Texas Labor Code §406.010, which authorizes the commission to adopt rules regarding claims service; Texas Labor Code §406.011, which allows the commission to require insurance carriers to designate an Austin representative to act as an agent for the insurance carrier and accept service on behalf of the carrier; Texas Labor Code §406.031, which holds an insurance carrier liable for compensation for an eligible employee's injury arising out of and in the course and scope of employment; Texas Labor Code §408.021, which provides that the injured employee is entitled to all health care reasonably required by the nature of the injury as and when needed; Texas Labor Code §408.023, which authorizes the commission to develop a list of approved doctors; Texas Labor Code §408.025, which authorizes the commission to adopt requirements for reports and records that are required to be filed with the commission by health care providers; Texas Labor Code §408.027, which provides for insurance carrier payment of health care providers; Texas Labor Code §409.003, which allows an employee or their representative to file a claim for compensation within one year from the date of injury; Texas Labor Code §409.009, which allows a person to become a sub-claimant to a workers' compensation claim; Texas Labor Code §409.021, which governs an insurance carrier's obligation regarding initiation of benefits; Texas Labor Code §409.041, which establishes the commission's Ombudsman program; Texas Labor Code §413.013, which authorizes the commission to establish programs for the retrospective review and resolution of disputes regarding health care treatments and services; Texas Labor Code §413.015, which directs insurance carrier payments to and audits of health care providers; Texas Labor Code §413.031 which directs medical dispute resolution; Texas Labor Code §413.042 which prohibits private claims; and Texas Civil Practice and Remedies Code, Chapter 146, which directs that health care providers submit bills no later than the 11th month in which the service was provided.

The previously cited sections of the Texas Labor Code are affected by this rule action. No other code or statute is affected by this rule action.

§133.308. Medical Dispute Resolution by Independent Review Organizations.

(a) Applicability. This rule is to be applied as follows.

(1) This rule applies to the independent review of prospective or retrospective medical necessity disputes (a review of health care requiring preauthorization or concurrent review, or retrospective review of health care provided) for which the dispute resolution request was filed on or after January 1, 2003. Dispute resolution requests filed prior to January 1, 2003 shall be resolved in accordance with the rules in effect at the time the request was filed. When applicable, retrospective medical necessity disputes shall be governed by the provisions of §133.309 of this title (relating to Alternate Medical Necessity Dispute Resolution by Case Review Doctor), effective for dispute resolution requests filed on or after October 1, 2004. All independent review organizations (IROs) performing reviews of health care under the Texas Workers' Compensation Act (the Act), regardless of where the independent review activities are based, shall comply with this rule.

(2) The review of medical necessity by an IRO will be determined in the following priority:

(A) prospective medical necessity disputes;

(B) employee reimbursement disputes; and

(C) retrospective medical necessity disputes.

(b) TDI Rules. Each IRO performing independent review of health care provided in the workers' compensation system shall be certified by TDI pursuant to Art. 21.58C, of the Texas Administrative Code, and must comply with TDI rules regarding General Provisions and Certification of IROs, Title 28, Part 1, Chapter 12, Subchapters A and B. In addition, TDI rules in Title 28, Part 1, Chapter 12, Subchapters C through F apply to workers' compensation cases except as modified or noted below:

(1) Where the word "patient" is used in those TDI rules, it shall mean the injured employee.

(2) Where any of the terms "health insurance carrier," "health maintenance organization," or "managed care entity" is used in those TDI rules, it shall mean the carrier or its agent.

(3) The Texas Labor Code and commission rules govern the independent review process and related substantive areas, including: requests, filing, notification, time deadlines, parties, billing, payment, appeal from an adverse IRO decision, and other matters addressed in this rule.

(4) A provider who has been removed from the commission Approved Doctor List is not eligible to direct or conduct independent reviews of workers' compensation cases.

(5) The provisions regarding a "life-threatening condition" are not applicable because in the workers' compensation system, emergency health care does not require prospective approval.

(6) In addition to confidentiality requirements in those TDI rules, an IRO shall preserve the confidentiality of claim file information that is confidential pursuant to the Texas Labor Code.

(7) Conflicts of interest will not be screened by TDI; the commission shall screen for conflicts of interest to the extent reasonably possible. (Notification of each IRO decision must include a certification by the IRO that the reviewing provider has certified that no known conflicts of interest exist between that provider and any of the treating providers or any of the providers who reviewed the case for determination prior to referral to the IRO.)

(8) The commission will monitor the activity, quality and outcomes of IRO decisions.

(c) Parties. The following persons are allowed to be requestors and respondents in medical necessity dispute resolution:

(1) In a retrospective necessity dispute - the provider who was denied payment for health care rendered, the employee denied reimbursement for health care for which the employee paid, and the carrier.

(2) In a prospective preauthorization dispute - persons or entities as established in §134.600 of this title (relating to Procedure for Requesting Pre-Authorization of Specific Treatments and Services).

(3) In a prospective concurrent review dispute - the provider and the carrier.

(d) Requests. A request for independent review of a medical necessity dispute shall be timely filed by the requestor with the division.

(e) Timeliness. A person or entity who fails to timely file a request waives the right to independent review or medical dispute resolution. The commission shall deem a request to be filed on the date the division receives the request, and timeliness shall be determined as follows:

(1) A request for retrospective necessity dispute resolution of a medical bill pursuant to §133.304, of this title (relating to Medical Payments and Denials), shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in the dispute.

(2) A request for prospective necessity dispute resolution shall be considered timely if it is filed with the division no later than the 45th day after the date the carrier denied approval of the party's request for reconsideration of denial of health care that requires preauthorization or concurrent review pursuant to the provisions of §134.600.

(f) Request (General). A request for independent review must be filed in the form, format, and manner prescribed by the commission. The requestor shall file two copies of the request with the division by any mail service or personal delivery, the division will forward one copy of the request to the insurance carrier via its Austin representative, the representative shall sign for the request. Each copy of the request shall be legible, shall include only a single copy of each document, and shall include:

(1) A designation that the request is for review by Independent Review Organization;

(2) Written notices of adverse determinations (both initial and reconsideration) of prospective or retrospective necessity disputes, if in the possession of the requestor;

(3) Documentation of the request for and response to reconsideration, or, if the respondent failed to respond to a request for reconsideration, convincing evidence of carrier receipt of that request;

(4) For medical necessity disputes:

(A) for retrospective necessity disputes, a table of disputed health care denied for lack of medical necessity, which includes complete details of the dispute issues in accordance with §133.304; or

(B) for prospective necessity disputes, a detailed description of the health care requiring preauthorization and/or concurrent review and approval in accordance with §134.600;

(5) A list of any and all providers that have examined or provided health care to the employee during the course of the workers' compensation claim;

(6) list of all providers that participated in the review or determination by the carrier, if known by the requestor; and

(7) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission.

(g) Carrier Notification to the Commission. The carrier shall complete the remaining sections of the request form and shall provide any missing information required on the form, which shall include:

(1) The respondent information;

(2) A list of any additional providers that have examined, provided, or rendered health care to the employee at any time during the course of the worker's compensation claim;

(3) Notices of adverse determinations of prospective or retrospective medical necessity, not provided by the requestor; and

(4) A list of all providers that participated in the review or determination by the carrier, if known by the requestor.

(h) Response. The carrier shall file the response to the request with the division and the requestor by facsimile or other electronic means within seven (7) calendar days of receipt of the request for review by the IRO for prospective preauthorization disputes and 14 calendar days for retrospective medical necessity disputes.

(i) Dismissal. A dismissal does not constitute a decision. The commission may dismiss a request for medical necessity dispute resolution if:

(1) The requestor informs the commission, or the commission otherwise determines, that the dispute no longer exists;

(2) The individual or entity requesting medical necessity dispute resolution is not a proper party to the dispute per subsection (c) of this section;

(3) The commission determines that the medical bills in the dispute have not been properly submitted to the carrier for reconsideration pursuant to §133.304;

(4) The fee disputes for the date(s) of health care in dispute have been previously adjudicated by the commission;

(5) The request for dispute resolution is untimely;

(6) The requestor fails to remit the fee for an IRO review;

(7) The request for medical dispute resolution does not contain all the components required by the TWCC-60 form and by subsection (e) or (f) of this section. The requestor may amend and resubmit the request to include all the required components as long as the amended request is filed within the timeframes required by subsection (d) of this section, and the request was not previously dismissed for lack of an IRO fee payment; or

(8) The commission determines that good cause exists to dismiss the request.

(j) TWCC Notification of Parties. The commission shall review the request for IRO review, assign an IRO with which no conflict of interest exists, and notify the parties and the IRO of the assignment, by a verifiable means of delivery. The commission will assign disputes on a rotating basis to the IROs certified by TDI, in accordance with Insurance Code article 21.58C and TDI rules. The commission may assign disputes in accordance with the priorities established in this rule and in a manner other than a rotating basis if necessary because of insufficient IRO capacity.

(k) IRO Notification of Parties. The IRO shall also notify the parties of the assignment and require that documentation be sent directly to the assigned IRO and received not later than the seventh day after the party's receipt of the IRO notice. The documentation shall include:

(1) Any medical records of the injured employee relevant to the review;

(2) Any documents used by the utilization review agent or carrier in making the decision, to be reviewed by the IRO; and

(3) Any supporting documentation submitted to the utilization review agent or carrier.

(l) Confidentiality. No IRO or provider is required to obtain the written consent of the injured employee as a prerequisite to obtaining or releasing medical records relevant to the review in a workers' compensation medical dispute. The IRO shall preserve confidentiality of individual medical records as required by law.

(m) Additional Information. The IRO may request additional relevant information from either party or from other providers whose records are relevant to the dispute, to review the medical issues in a dispute. The party shall deliver the requested information to the IRO as directed. The additional information must be received by the IRO within 14 days of receipt of the request for additional information. If the provider requested to submit records is not a party to the dispute, then copy expenses for the requested records shall be reimbursed by the carrier pursuant to §133.106 of this title (relating to Fair and Reasonable Fees for Required Reports and Records). Reimbursement for copies may not be permitted for a party to the dispute.

(n) Designated Doctor Exam. In performing a review of medical necessity, an IRO may request that the commission order an examination by a designated doctor and order the employee to attend the examination. The IRO request to the commission must be made no later than 10 days after the IRO receives notification of assignment of the IRO. The treating doctor and carrier shall forward a copy of all medical records, diagnostic reports, films, and other medical documents to the designated doctor appointed by the commission, to arrive no later than three days prior to the scheduled examination. Communication with the designated doctor is prohibited regarding issues not related to the medical dispute. The designated doctor shall complete a report and file it with the IRO, on the form and in the manner prescribed by the commission, no later than seven working days after completing the examination. The designated doctor report shall address all issues the commission instructed the doctor to address.

(o) Time Frame for IRO Decision. The IRO will review and render a decision on retrospective medical necessity disputes by the 30th day after the IRO receipt of the dispute. The IRO will review and render a decision on prospective necessity disputes by the 20th day after the IRO receipt of the dispute. If a designated doctor examination has been requested by the IRO, the above time frames begin from the date of the IRO receipt of the designated doctor report.

(p) IRO Notification of Decision.

(1) Notification of decision by the independent review organization must include:

(A) the specific reasons, including the clinical basis, for decision;

(B) a description and the source of the screening criteria that were utilized;

(C) a description of the qualifications of the reviewing physician or provider; and

(D) a certification by the IRO that the reviewing provider has certified that no known conflicts of interest exist between that provider and any of the treating providers or any of the providers who reviewed the case for decision prior to referral to the IRO.

(2) The notification in a retrospective necessity dispute must be mailed or otherwise transmitted to the commission not later than the 30th day after the IRO receipt of the dispute.

(3) The notification in a prospective necessity dispute must be delivered to the parties not later than the 20th day after the IRO receipt of the dispute.

(4) The notification to the commission shall also include certification of the date and means by which the decision was sent to the parties.

(5) An IRO decision is deemed to be a commission decision and order.

(6) If an IRO decision finds that medical necessity exists for care that the carrier denied, and the carrier utilized the opinion of a peer review or other case review to issue its denial, the review and its rationale shall not be used on subsequent denials in that claim as the IRO has already found it unconvincing for the disputed health care.

(q) Commission Posting. The commission shall post the IRO decision on the commission Internet website after confidential information has been redacted.

(r) IRO Fees. IRO fees shall be paid as follows.

(1) Upon receipt of an IRO assignment:

(A) in a prospective dispute or an employee reimbursement dispute, the carrier shall remit payment to the assigned IRO at the same time the carrier files the documentation requested by the IRO;

(B) in a retrospective dispute, the requestor shall remit payment to the assigned IRO at the same time the requestor files the documentation requested by the IRO.

(2) Upon receipt of an IRO decision in a retrospective necessity dispute other than an employee reimbursement dispute, and in a concurrent review prospective necessity dispute, the commission shall review the decision to determine the prevailing party and, if applicable, will order the nonprevailing party to refund the IRO fee to the party who prevailed by CCH or SOAH decision.

(A) If the IRO decision as to the main issue in dispute is a finding of medical necessity, the requestor is the prevailing party.

(B) If the IRO decision does not find medical necessity with respect to the main issue in dispute, the respondent is the prevailing party.

(C) if the IRO decision does not clearly determine the prevailing party, the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

(3) The IRO shall bill copy expenses to the party liable for the independent review; provided, however, that no copy costs shall be paid to the requestor.

(4) The injured employee shall not be required to pay any portion of the cost of a review.

(5) Designated doctor examinations ordered by the commission at the request of an IRO, shall be paid by the party who is liable for the IRO fee in accordance with the appropriate fee guideline.

(6) IRO fees will be paid in the same amounts as those set by TDI rules for tier one and tier two fees. In addition to the specialty classifications established as tier two fees in TDI rules, independent review by a doctor of chiropractic shall be paid the tier two fee.

(7) If the fee has not been received by the IRO within 7 days of the party's receipt of notice from the IRO, the IRO shall notify the commission and the commission shall issue an order to pay the IRO fee.

(8) Failure to pay or refund the IRO fee may result in enforcement action as allowable by statute and rules, removal from the commission Approved Doctor List, and/or restriction of future requests for independent review.

(9) A party required to pay or refund the IRO fee to the other party is liable for that fee upon receipt of the order from the commission regardless of whether an appeal of the IRO decision has been or will be filed.

(10) If the IRO decision is subsequently reversed or differently decided at a CCH or by a SOAH decision, the commission shall order a refund of the IRO fee to be paid the party who prevailed by CCH or SOAH decision within 10 days of receipt of the order.

(11) The requestor may be liable for the IRO fee if the request is withdrawn or the review is terminated prior to completion.

(12) The fees provided for IRO review may include a second review of dispute issues if the initial decision is determined by the commission to be incomplete. The amended or corrected decision shall be filed with the division within 5 days of the IRO receipt of such notice from the commission.

(s) Defense. It is a defense for the carrier if the carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an injured employee. If a previously timely filed request for fee dispute resolution exists at the time the IRO issues a decision of medical necessity, the carrier is not required to pay for the disputed health care until the commission has resolved the medical fee dispute. If there is no previously pending request for medical fee resolution, the carrier shall immediately comply with the IRO decision.

(t) Unresolved Fee Disputes. If an unresolved fee dispute issue exists at the time the commission receives the IRO decision in a dispute, the commission shall then proceed to resolve the medical fee dispute in accordance with commission rules.

(u) Appeal. Except with respect to a prospective necessity dispute regarding spinal surgery, a party to a prospective or retrospective necessity dispute may appeal the IRO decision by filing a written request for a SOAH hearing with the commission Chief Clerk of Proceedings, Division of Hearings in accordance with §148.3 of this title (relating to Requesting a Hearing).

(1) The appeal must be filed no later than 20 days from the date the party received the IRO decision.

(2) The party appealing the IRO decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

(3) The commission shall file the request for hearing with SOAH.

(4) The hearing shall be conducted by the State Office of Administrative Hearings within 90 days of receipt of a request for a hearing in the manner provided for a contested case under Chapter 2001, Government Code (the administrative procedure law).

(5) Notwithstanding other provisions of this rule or any other rules, the acquiring, providing, assembling, filing and offering of documents at any *de novo* hearing (a new hearing based upon evidence admitted at the SOAH hearing) conducted by the State Office of Administrative Hearings on or after March 1, 2003, whether or not previously exchanged, is the responsibility of the requestor and respondent. Admission and use of such documents at the hearing are controlled by the procedural Rules of the State Office of Administrative Hearings. The commission will not file a copy of the record of the service review by the division with SOAH or any party for a hearing scheduled to be conducted by SOAH (or continued to a date) on or after March 1, 2003.

(6) The parties to the dispute must represent themselves before SOAH, and the IRO is not required to participate in the SOAH hearing.

(7) A party who has exhausted the party's administrative remedies under this subtitle and who is aggrieved by a final decision of the State Office of Administrative Hearings may seek judicial review of the decision. Judicial review under this subsection shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

(8) The commission shall post the SOAH decision on the commission website after confidential information has been redacted.

(v) Spinal Surgery Appeal. A party to a prospective necessity dispute regarding spinal surgery may appeal the IRO decision by requesting a Contested Case Hearing ("CCH").

(1) The written appeal must be filed with the commission Chief Clerk of Proceedings, Division of Hearings, within 10 days after receipt of the IRO decision and must be filed in compliance with §142.5(c) of this title (relating to Sequence of Proceedings to Resolve Benefit Disputes).

(2) The CCH will be scheduled and held within 20 days of commission receipt of the request for a CCH.

(3) The hearing and further appeals shall be conducted in accordance with Chapters 140, 142, and 143 of this title (relating to Dispute Resolution/General Provisions, Benefit Contested Case Hearing, and Review by the Appeals Panel).

(4) The party appealing the IRO decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute; the IRO is not required to participate in the CCH or any appeal.

(w) In all appeals from reviews of prospective or retrospective necessity disputes, the IRO decision has presumptive weight.

(x) The commission is entitled to review, inspect, copy, and/or compel production of documents or other information as necessary to carry out the commission's duties and responsibilities under this rule, the Act, and other applicable statutes.

(y) If the commission believes that any person is in violation of the Act or this rule, the commission may initiate appropriate compliance and enforcement action. If the commission believes that any person is in violation of the Insurance Code or TDI rules, the commission may initiate appropriate action in accordance with any Memorandum of Understanding between the Texas Department of Insurance and the commission. Nothing in this rule modifies or limits the authority of the department or the commission.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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28 TAC §133.309

The Texas Workers' Compensation Commission (the commission) adopts new rule §133.309, concerning Alternate Medical Necessity Dispute Resolution by Case Review Doctor (AMDR), with changes to the proposed text published in the March 5, 2004, issue of the *Texas Register* (29 TexReg 2187). AMDR is a process to resolve retrospective medical necessity disputes of medical services costing less than the cost of a review by an independent review organization (IRO).

As required by the Government Code §2001.033(l), the commission's reasoned justification for this rule is set out in this order, which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support or opposition to adoption of the rule, and the reasons why the commission disagrees with some of the comments and proposals.

Changes were made to the proposed rule in response to public comment received in writing and at a public hearing held on April 14, 2004, and are described in the summary of comments and responses section of this preamble. Changes were also made to the proposed rule in response to comments and concerns raised by the commissioners at the June 17, 2004 public meeting regarding initial payment of the case review fee. Other changes were made for consistency or upon further consideration and clarification as a result of concepts shared through public comments.

This new rule is adopted pursuant to the statutory provisions in Texas Labor Code §413.031. House Bill 3168 (HB-3168), adopted during the 2003 Texas Legislative Session, amended §413.031 to add a new subsection (m) regarding new authority for commission medical dispute resolution. This new statutory provision states that the commission by rule may prescribe an alternate dispute resolution process to resolve disputes regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization. With the exception of injured employees, who, by rule, will never be required to pay the case review fee, the nonprevailing party shall pay the cost of a review under the alternate dispute resolution process.

Commission Rules 133.305 (regarding Medical Dispute Resolution - General), 133.307 (regarding Medical Dispute Resolution of a Medical Fee Dispute), and 133.308 (regarding Medical Dispute Resolution by Independent Review Organizations) are the commission's current medical dispute resolution processes. These rules are the current processes for resolving medical necessity disputes (prospective and retrospective) and medical fee disputes.

Commission staff resolves medical fee disputes. Prospective and retrospective medical necessity reviews are conducted by an IRO under Article 21.58C, Texas Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. IROs are entities certified by the Texas Department of Insurance (TDI) to conduct independent review of the medical necessity and appropriateness of health care services that have been provided or are proposed to be provided. Assessments of the IRO fees are based on TDI's two-tiered structure. The tier one fee is currently $650.00 for disputes that are reviewed by a medical doctor, or a doctor of osteopathy. The tier two fee is currently $460.00 for disputes that are reviewed by a medical professional other than a medical doctor or a doctor of osteopathy. This new adopted rule establishes the exclusive process for retrospective review of medical necessity disputes where the sum of disputed billed charges is less than the tier one fee.

The adopted new rule is designed to provide an alternative for resolving disputed services that are less than the IRO fee. During the two-year period of January 2002 through December 2003, approximately 1,100 of the 5,900 retrospective medical dispute filings involved disputes of care with charges totaling less than the tier one IRO fee. Approximately 60% of these disputes were withdrawn or dismissed and were not resolved through the current process, due in part to the IRO fee. An anticipated benefit to all system participants is that a greater number of these disputes will proceed to a resolution under the streamlined AMDR process. The IRO fee has been a barrier to the resolution of low-dollar medical necessity disputes. The removal of the fee barrier should result in more disputes being received and timely processed by the commission.

As an example, pharmacists often fill prescriptions and are denied reimbursement for medical necessity reasons. The prescription reimbursement is often much lower than the cost of the IRO process to the pharmacist, causing the pharmacist to make a business decision as to whether it is cost effective to pursue

a dispute through the IRO process. Using another example, injured employees at times personally pay for prescriptions and treatments. This may occur when the health care provider indicates that the carrier will deny reimbursement of associated bills. These events often result in the pharmacist or other health care provider not being reimbursed, or the injured employee not being able to recoup out-of-pocket expenses. Additionally, it is often difficult for the pharmacist or injured employee to obtain the prescribing physician's documentation of the prescription's or treatment's medical necessity. Without this documentation, it is unlikely that the pharmacist or injured employee will prevail in the dispute. This adopted new rule mandates that the prescribing/referring doctor provide the required documentation to the health care provider requesting AMDR.

There are other significant benefits with this adopted new process, which include the following elements:

* Expedited resolution through a compressed timeframe of approximately 30 days;

* Procedural assistance to injured employees from the commission;

* A case review fee consistent with low-dollar dispute amounts;

* Utilization of case review doctors from the commission's Approved Doctor List (ADL);

* Consolidation of multiple claim-specific medical bills for consideration;

* Restrictions on the amount of documentation allowed for processing and resolution;

* Conclusion of the dispute when the case review doctor submits the final decision and order to all parties and the commission;

* Assignment of responsibility for the case review fee to the nonprevailing party (except for the injured employee); and

* Required reimbursement within 20 days of receipt of the final decision and order.

System participants on the whole should benefit from the adopted rule due to reduced costs in the system as well as payment for medical care to which an injured employee is entitled, and non-payment of care that is not reasonably required for the compensable injury. More specifically, health care providers and injured employees will experience reduced costs in participating in the retrospective medical necessity dispute process due to the lower cost associated with an AMDR review. Also, health care providers now have the ability to obtain reimbursement for disputed health care that would otherwise not be pursued due to the expense of an IRO review.

The injured employee will benefit from the elements of the adopted new rule designed to simplify the process in comparison to the current process. The adopted rule requires the injured employee to only obtain one denial for reimbursement in order to be eligible for the AMDR process and is not required to request reconsideration of denied bills. A request by an injured employee shall be initiated by contacting the commission in any manner for assistance with the AMDR requirements. The injured employee's initial contact establishes the date used to determine timeliness. The commission anticipates providing injured employees assistance as needed in compiling the information necessary to complete their request. In total, these elements will promote a quicker resolution of the dispute as evidenced by the timeframe that does not exceed 30 days. The injured employee will also benefit from the requirement that reimbursement of health care services previously paid by the injured employee be made within 20 days of this final decision and order. In addition the injured employee will also benefit from limitations placed on the amount of required documentation to be submitted with a request. The adopted new rule allows for the consolidation of multiple claim-specific medical bills to be included in an AMDR request. This has the potential to reduce costs and complexity for injured employees participating in this dispute resolution process.

Similarly, health care providers will also benefit from limitations placed on the amount of required documentation to be submitted with a request. This will result in easier access for health care providers and will ultimately promote quicker resolution of the dispute. As previously stated, the case review fee is consistent with low-dollar dispute amounts making the AMDR process less costly and, consequently, a more viable option for health care providers.

Insurance carriers will also benefit from limitations placed on the amount of required documentation to be submitted with a request, as this will ultimately promote quicker resolution of the dispute. Insurance carriers should experience a reduction in costs associated with low-dollar disputes filed by injured employees that were previously resolved through the IRO process at the carrier's expense. Insurance carriers will also benefit from receiving the final decision and order directly from the case review doctor, and from the requirement that reimbursement of the case review fee be made within 20 days of receiving this final decision and order. As previously stated, the nonprevailing party, excluding the injured employee, is responsible for the case review fee. The adopted new rule allows for the consolidation of multiple claim-specific medical bills to be included in an AMDR request. This has the potential to reduce costs and complexity for insurance carriers participating in this dispute resolution process.

Currently, the IRO process does not encourage the review of low-dollar medical necessity disputes, as the cost of an IRO review is disproportionately high relative to the value of the services in question. Consequently, health care providers and injured employees have borne the cost of these services without a reasonable forum for disputing an insurance carrier's denial of reimbursement. The adopted AMDR process offers the opportunity for low-dollar medical necessity disputes to be expeditiously resolved in a cost effective forum, which is a system-wide benefit. Moreover, it is expected that the AMDR forum will encourage insurance carriers to proactively scrutinize low-dollar services for proper adjustment, thereby reducing administrative burdens and lowering overall system costs.

Adopted new §133.309 establishes a process to resolve retrospective medical necessity disputes of medical services costing less than the cost of a review by an independent review organization (IRO). The new rule is designed to provide the exclusive process for retrospective review of medical necessity disputes where the sum of disputed billed charges is less than the tier one fee for an IRO review.

There is a change to subsection (a) of the rule as proposed. Subsection (a) establishes definitions for terms used and referenced in this process. The rule as proposed provided a definition for "case review doctor" in paragraph (1) that has now been expanded to clarify that a case review doctor is a commission selected doctor from the commission's ADL assigned to conduct retrospective review of health care for medical necessity under this subsection.

There are changes to subsection (b) of the rule as proposed. Subsection (b) establishes applicability. AMDR is the exclusive process to resolve claim-specific retrospective medical necessity disputes where the amount in dispute is less than the tier one fee for an IRO review. This rule applies to AMDR disputes filed with the commission on or after October 1, 2004, changed from August 1, 2004 in the proposal to allow for development of necessary infrastructure and training to implement AMDR. Subparagraphs (1)(A) and (B) establish that the permissible sum of disputed billed charges on a single or on multiple bills is less than the tier one fee as established for the review of health care by an IRO. Additionally, subparagraph (1)(B) limits multiple billings to bills from a single health care provider. The commission further clarifies, in response to concerns from pharmacists regarding aggregation of bills from multiple physicians, that in the rare circumstance that disputed prescriptions for a single, injured employee come from multiple providers, whether claimed on a single bill or multiple billings, the pharmacy must dispute these separately. Paragraph (2) is changed to reflect the new effective date of October 1, 2004. Paragraph (3) expressly limits the use of AMDR to the resolution of retrospective medical necessity disputes as defined in subparagraphs (1)(A) and (B). Paragraph (4) prohibits disputes adjudicated through the IRO or SOAH processes from being subsequently reviewed under the AMDR process. Paragraph (5) directs that disputes in which the sum of billed charges is greater than or equal to the tier one IRO fee must be filed and processed in accordance with §133.308 (relating to Medical Dispute Resolution by Independent Review Organizations). A change in the effective date for AMDR is also reflected in this paragraph. Paragraph (6) directs that disputes regarding the amount of payment for health care rendered must be filed and processed in accordance with §133.307 (relating to Medical Dispute Resolution of a Medical Fee Dispute) and any claim-related disputes must be filed and processed in accordance with §141.1 (relating to Requesting and Setting a Benefit Review Conference). Paragraph (7) provides for the ongoing application of AMDR to appropriate disputes if a court of competent jurisdiction invalidates some provision or application of the rule. These provisions are necessary to provide clarity on applicability and to prevent circumvention of the various medical dispute resolution processes through bundling or unbundling of health care services.

There is a change to subsection (c) of the rule as proposed. Subsection (c) addresses the effects of other disputes on the AMDR process. Paragraph (1) addresses the impact of §409.021 (relating to Initiation of Benefits; Insurance Carrier's Refusal; Administrative Violation) in instances where care has been provided for the claimed injury and the insurance carrier has not yet disputed compensability of the claim. The provision makes it clear that the carrier will be liable for all medically necessary care that was provided for the claimed injury prior to the insurance carrier's dispute of compensability. As such, the request for AMDR will proceed to a final decision and order. Paragraph (2) provides that the insurance carrier is liable for any medically necessary care that has been provided for the claimed injury if the insurance carrier has still not disputed liability or compensability and the 60-day period to do so, or a later period if there is a finding of evidence that could not reasonably have been discovered earlier, under §409.021 has lapsed. Again, the request for AMDR will proceed to a final decision and order. The paragraphs (1) and (2) are necessary to address the recent legislation that changed the time frame in §409.021 from seven to fifteen days in response to the Texas Supreme Court's decision in Continental Casualty Co. v. Downs, 81 S.W. 3d 803 (Tex. 2002) and to ensure consistency. Insurance carriers are liable for all benefits that accrue from the date of injury, and must either initiate payments that are due or dispute the claim's compensability by the 15th day after the date the insurance carrier receives written notice of the claimed injury. The insurance carrier has 60 days after the date it receives written notice of the claimed injury to investigate the claim and decide whether to contest compensability. The only exception to the 60-day time limit is that, if there is a finding of evidence that could not reasonably have been discovered earlier, the insurance carrier may reopen the issue of compensability. If the insurance carrier does not timely dispute compensability, it waives its right to contest compensability, and becomes liable for all benefits that accrue, whether medical or indemnity. However, even if the claim is accepted as compensable, medical necessity and fee issues remain subject to potential dispute resolution. Paragraph (3) is changed so that, if a carrier has denied a claim's compensability, the AMDR process will not continue until after final adjudication by the commission finds liability and compensability for the injury. Paragraph (4) as proposed is therefore deleted as is proposed paragraph (6). New paragraph (4) retains the text from proposed paragraph (5) and establishes that where a claim's compensability has been adjudicated or accepted, and liability for the claim has been adjudicated or accepted, the AMDR request shall proceed to a final decision and order. The provisions of subsection (c) are necessary for clarity, consistency with statute and rules, and to prevent circumvention of the statute and rules through the timing of the filing of various types of disputes.

There is a change to subsection (d) of the rule as proposed. Subsection (d) establishes who the parties in the AMDR process shall be, and language is added in paragraph (2) from proposal to clarify that the terms prescribing doctor and referring doctor are used interchangeably for AMDR purposes. This is also a clarification by the commission, in response to many comments from physical therapists, of its position that a doctor who prescribes medicines or refers injured employees for physical therapy (whether by specifically prescribed protocol, or by nonspecific order for evaluation and treatment) is a necessary party for AMDR purposes. Those purposes include providing documentation supporting the medical necessity of prescribed/referred care and being accountable for reimbursement of the $100 case review fee in the event that a prescription to a pharmacy or durable medical equipment supplier is found to be not medically necessary. Therefore, the parties to the AMDR process shall be: the health care provider; the prescribing/referring doctor, if other than the health care provider who provided the care in dispute; the injured employee, if denied reimbursement for health care paid by the injured employee; and the carrier. The carrier participates in this process as a responding party and shall not be considered a requesting party.

There is a change to subsection (e) of the rule as proposed by adding the word "only." Subsection (e) addresses timeframes for filing an AMDR dispute. A request must be filed with, and received by, the commission no later than one year from the disputed health care's date of service. The change clarifies that health care providers must adhere to the reconsideration process in accordance with §133.304 (relating to Medical Payments and Denials) prior to requesting AMDR. However, an injured employee seeking reimbursement is not required to request reconsideration. Additionally, paragraph (2) provides that an injured employee may initiate AMDR by contacting the commission in any manner, and that this initial contact establishes the date used to determine timeliness for an injured

employee's request. Paragraph (3) states that any party that does not timely file a request for review waives the right to AMDR.

There are changes to subsection (f) of the rule as proposed. Subsection (f) establishes criteria for complete requests submitted by health care providers. Paragraph (1) requires that two legible copies of the request be submitted to the commission, which prescribes the form and manner of the request. The elements of the request are described in subparagraphs (2)(A - D) and include: a designation that the request is for review under AMDR; a copy of medical bill(s); copies of written notices of denials from the carrier (explanations of benefits (EOBs)), or, if no response from the carrier, verifiable evidence or documentation of the carrier's receipt of the request. Subparagraph (f)(2)(D) is changed from the proposed maximum of three single-sided pages of documentation supporting the medical necessity of disputed care to an adopted maximum of five single-sided documents, which may include a summary, supporting the medical necessity of disputed care. These five pages of documentation may also consist of excerpts of medical records. The change from three pages to five single-sided documents is in response to public comments recommending a more reasonable amount of documents required to support the dispute, and maintains the intent of a manageable and expedited review by the case review doctor. The terminology for the prescribing doctor has been changed to prescribing/referring doctor in accordance with and for the same reasons as changed in adopted (d)(2) of this section. The prescribing/referring doctor must provide the necessary documentation to the requesting party, if needed. Failure of the prescribing/referring doctor to provide the needed documentation may subject the doctor to an enforcement action.

There is a change to subsection (g) of the rule as proposed. Subsection (g) establishes criteria for complete requests submitted by injured employees. The elements of the request are described in paragraphs (1 - 4) and include: a designation that the request is for review under AMDR; documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider; and a copy of any written notice of adverse determinations such as an EOB indicating that reimbursement is denied due to the health care not being medically necessary, or, if the carrier fails to respond to the request for reimbursement, verifiable evidence or documentation of the carrier's receipt of the request. Paragraph (g)(4) is changed from the proposed maximum of three single-sided pages of documentation supporting the medical necessity of disputed care to the adopted maximum of five single-sided documents which may include a summary supporting the medical necessity of disputed care, clearly identified as the documentation to be reviewed by the case review doctor. These five pages of documentation may also consist of excerpts of medical records. The change from three pages to five single-sided documents is in response to public comments recommending a more reasonable amount of documents required to support the dispute, and maintains the intent of a manageable and expedited review by the case review doctor. The terminology for the prescribing doctor is changed to prescribing/referring doctor in accordance with and for the same reasons as changed in (d)(2) of this section. The prescribing/referring doctor must provide the necessary documentation to the requesting party, if needed. Failure of the prescribing/referring doctor to provide this documentation may subject the doctor to an enforcement action. The commission anticipates providing injured employees with assistance, as needed, in compiling this information.

There is a change to subsection (h) of the rule as proposed. Subsection (h) describes the commission's assignment of a case review doctor, within 10 days of receipt of a complete request for AMDR, to resolve the medical necessity dispute. The case review doctor will be selected, at the commission's discretion, from the commission's ADL, with appropriate qualifications. The case review doctor shall be considered a doctor performing medical case review for purposes of section 413.054 of the Act. This provision affords the case review doctor immunity from civil liability for an act performed in good faith in the execution of those duties. The doctors utilized by the commission for this process will be of a sufficient number to service the volume of AMDR requests. A case reviewer must be of the same or similar licensure as the prescribing/referring or performing doctor and have no known conflicts of interest with any of the providers known by the case review doctor to have examined, treated or reviewed records for the injured employee's injury claim. Again, the terminology for the prescribing doctor is changed to prescribing/referring doctor in accordance with and for the same reasons as changed in (d)(2) of this section. Additionally, the case review doctor may not have previously treated or examined the injured employee within the past 12 months, nor have examined or treated the injured employee with regard to a medical condition being evaluated in the AMDR request. The case reviewer must preserve the confidentiality of individual medical records as required by law. Written consent by the injured employee is not required for the case review doctor to obtain medical records relevant to the review.

There are changes to subsection (i) of the rule as proposed. Subsection (i) describes the notification order. The commission issues the notification order to the parties within 10 days of receipt of a complete request for AMDR. The written notification contains the following elements: the case reviewer's name, license number, practice address, telephone number and fax number; an explanation of the purpose of the case review; an order for the requestor to pay the case review fee to the case review doctor no later than 14 days from the date of the order, unless the requestor is an injured employee, in which case the carrier is ordered to pay the case review fee; and an advisory to the carrier to forward a written response to the case review doctor. The element regarding initial payment of the case review fee is changed from proposal in accordance with changes made to subsection (j) requiring the requestor to pay the fee. The proposed requirement to advise the parties of a pending compensability and/or liability dispute in accordance with subsection (c) is deleted because of the changes made to subsection (c). Additionally, subsection (i) states that the commission's notice to the carrier shall also include a copy of the AMDR request. The notice shall be forwarded to the carrier through its Austin representative. The carrier is deemed to have received the notification order and request for AMDR in accordance with §102.5(d) of this title (regarding General Rules for Written Communication to and from the Commission). Upon issuance of the notification order, withdrawals are not permitted by any party.

There are changes to subsection (j) of the rule as proposed. Subsection (j) sets the case review fee at $100.00. However, an injured employee is never required to pay this fee. In response to public comments and concerns raised by the commissioners, the rule is changed to require initial payment of the case review fee by the requesting party and not the carrier as proposed. The carrier will still be initially liable for the case review fee if the requestor is an injured employee, and ultimately liable if the carrier

does not prevail in accordance with subsection (n). This subsection is also changed to clarify that a requestor's failure to timely pay the case review fee will result in a dismissal of the AMDR request. The carrier's failure to timely pay the case review fee when the requestor is an injured employee will result in the issuance by the commission of an order to the carrier to pay the case review fee.

There are changes to subsection (k) of the rule as proposed. Subsection (k) describes the carrier response to an AMDR request. As recommended by public comments, the proposed timeframe for the carrier to submit a response is changed from seven days to 14 days. This change still allows for the case review doctor's report to be issued just under 30 days from initiation of the review. The adopted rule states that no later than 14 days from the date of the notification order, the carrier shall submit directly to the case review doctor: the $100.00 case review fee with an annotation identifying the case review number, when required (the case review fee is required to be provided by the carrier only when the requestor is an injured employee in accordance with changes made to subsection (j)); and a written response by facsimile or electronic transmission, either explaining why the disputed health care is not medically necessary, or indicating that no documentation will be submitted for review. Additionally, paragraph (k)(2) of the adopted rule is changed from the proposed maximum of three single-sided pages of supporting documentation to the adopted maximum of five single-sided documents, which may include a summary, supporting the carrier's position. These five pages of documentation may also consist of excerpts of medical records. The change from three pages to five single-sided documents is in response to public comments recommending a more reasonable amount of documents required to support the dispute, and maintain the intent of a manageable and expedited review by the case review doctor. If the carrier elects to not provide a response, the AMDR process will proceed to a final decision and order.

There are changes to subsection (l) of the rule as proposed. Subsection (l) outlines the case review. Based on public comments and consideration, a change has been made to section (l) and paragraph (l)(1) of the adopted rule changing the allowable number of pages of documentation from the proposed three to the adopted five single-sided documents provided by each party. This maintains the intent of a manageable and expedited review by the case review doctor for a fee of $100. If a party's documentation exceeds the limit of a maximum of five single-sided documents, the case review doctor shall not review any of the offending party's documentation and the case review doctor shall indicate this in the report. Further, if the case review doctor does not receive a timely response from the carrier, the case review doctor shall proceed with the review and issue the report required by (m) of this section. To avoid undue influence on the case review doctor, any communication regarding the AMDR dispute between a party and the case review doctor, before, during, or after the review, is prohibited. Upon completion of the case review, the case review doctor shall maintain a copy of the report, all documentation submitted by the parties, the date the documentation was received and from whom, and the date and time the report was issued to, and received by, all parties. Documentation of the date and time the report was successfully transmitted electronically to all parties is required for enforcement purposes in determining whether a party has timely complied with the order. If a party does not have the means to receive the report electronically, then the case review doctor shall provide the report via certified mail or other verifiable means. [See adopted (m)(2).] The case review doctor shall forward to the commission, upon request, copies of the retained information. These changes regarding retained documentation were made to ensure the commission's ability to enforce the provisions of the adopted rule. Compliance with commission rules and orders is essential to the system and represents an enforcement priority. Enforcing the AMDR decision and order could be problematic as the order is issued by the case review doctor on behalf of the commission. [See adopted (n).] To enforce such an order, the records maintained by the case review doctor must be readily available to the commission and contain the elements required by paragraph (l)(4). Failure of the case review doctor to comply with these retention requirements may result in the doctor being referred to the Compliance and Practices Division and/or the loss of future AMDR assignments.

There are no changes to subsection (m) of the rule as proposed. Subsection (m) describes the case review doctor's report, which must be completed within five days from the date the carrier's response was due. The report must include: the specific reasons for the case review doctor's determination, including the clinical basis for the decision; a description of, and the source of, the screening criteria that were utilized; a description of the qualifications of the case review doctor; and a certification by the case review doctor that no known conflicts of interest exist with any of the providers known by the case review doctor to have examined, treated or reviewed records for the injured employee's injury claim, and that the case review doctor has not previously treated or examined the injured employee within the past 12 months, nor has the case review doctor examined or treated the injured employee with regard to a medical condition being evaluated in the AMDR request. The case review doctor shall forward the completed report and a copy of the reviewed carrier's response to all parties and the commission. This information shall be forwarded by facsimile or electronic transmission. If the party is an injured employee and a facsimile number has not been provided, this information shall be provided by other verifiable means. Requests for clarification from the parties will not be accepted by the commission or the case review doctor. The commission, at its discretion, may seek clarification from the case review doctor and may require the case review doctor to issue an amended report within three days of the commission's request.

There are changes to subsection (n) of the rule as proposed. Subsection (n) describes the final decision and order. The case review doctor's report is deemed to be a commission decision and order, and is effective the date signed by the case review doctor. The decision and order is final and is not subject to further review. In paragraph (2), the terminology for the prescribing doctor has been changed to prescribing/referring doctor in accordance with and for the same reasons as changed in (d)(2) of this section. In response to public comment and concerns raised by the commissioners, (n)(2) of the rule has been changed to establish that if the decision and order indicates that none of the disputed care was medically necessary, the prescribing/referring doctor will be ordered to reimburse the requestor the case review fee only if the requestor is a pharmacy or durable medical equipment provider. No other parties shall reimburse, or be entitled to reimbursement of, the case review fee if the care is found not to be medically necessary. A change to proposed paragraph (n)(3) has been made to further clarify that if the decision and order indicates that any of the disputed care was medically necessary, the carrier will be ordered to pay, in accordance with commission's fee guidelines, for the care that was determined

by the case review doctor to be medically necessary. The carrier will also be ordered to reimburse the requestor the case review fee. The proposed language indicating that the decision and order shall identify any pending liability and/or compensability dispute as previously identified by the commission in accordance with subsections (c) and (i)(1)(E) has been deleted in accordance with changes to subsections (c) and (i). Correspondingly, the text stating that an AMDR decision and order favorable to the requestor is not enforceable absent an affirmative adjudication of any pending liability or compensability dispute has also been deleted, as has the reference to affirmative adjudication of a pending liability or compensability dispute in proposed subparagraph (n)(5)(B). Changes were made in response to recommendations received through public comment to proposed paragraph (n)(5), now (n)(4), to require a party to comply with the decision and order within 20 days, rather than the proposed five days. This provides a reasonable timeframe for compliance in line with existing business processes for payments. A change has also been made to the triggering event for the compliance period, starting the clock upon receipt, rather than issuance, of the AMDR order. The final decision and order shall not be used by a carrier to prospectively deny future medical care.

There are no changes to subsection (o) of the rule as proposed. Subsection (o) states that the commission may dismiss a request for AMDR if the commission determines that good cause exists.

The commission's Medical Advisor reviewed and made recommendations regarding this adopted rule.

Comments generally supporting new §133.309 as proposed were received from the following groups: Barkman & Smith Physical Therapy, Healthsouth, Henslee Therapy Associates, Insurance Council of Texas, Midland Memorial Hospital, OnSite Rehabilitation Services, Physical Therapy Services, PRS, Inc., Sante' Rehabilitation Group, Texas College of Occupational & Environmental Medicine, Texas Physical Therapy Association, Texas Pharmacy Association, and Work & Rehab.

Comments generally opposing or concerned with new §133.309 as proposed were received from the following groups: Advanced Orthopaedic Institute, American Insurance Association, Angleton Rehabilitation & Wellness Center, Barkman & Smith Physical Therapy, Bowie Memorial Hospital, CMI Barron Risk Management, Dallas Hand Rehabilitation, Envoy Medical Systems, Flahive, Ogden & Latson, Hardin-Simmons University, HealthSouth in Abilene, Henslee Therapy Associates, Independent Review, Inc., Insurance Council of Texas, Midland Memorial Hospital, North Texas Sports Medicine, OccUmed, Odessa Physical Therapy, OnSite Rehabilitation Services, Pain Care Center, Paris Regional Medical Center, Physical Therapy Pro, Physical Therapy Services, Property Casualty Insurers Association of America (PCI), PRS, Inc., ReCept Pharmacy, Revive Physical Therapy, Sante' Rehabilitation Group, South Austin Therapy Group, South San Physical Therapy, St. Joseph Regional Health Center, Stambush Health Care Services, Texas College of Occupational & Environmental Medicine, Texas Medical Association, Texas Medical Group Management Association, Texas Mutual Insurance Company, Texas Physical Therapy Association, Texas Sports Medicine Center, Texas Occupational Therapy Association, Inc. (TOTA), Texas Pharmacy Association, University of Texas Health Center at Tyler, West Texas Rehab Center, Westport Physical Therapy, Work & Rehab, and WorkSTEPS.

Comments neither generally supporting nor opposing new §133.309 as proposed, but suggesting changes or asking questions were received from the following groups: Advanced Orthopaedic Institute, American Insurance Association, Bowie Memorial Hospital, CMI Barron Risk Management, Envoy Medical Systems, Hardin-Simmons University, HealthSouth in Abilene, Insurance Council of Texas, Midland Memorial Hospital, OccUmed, Odessa Physical Therapy, OnSite Rehabilitation Services, Physical Therapy Services, Property Casualty Insurers Association of America (PCI), PRS, Inc., ReCept Pharmacy, Sante' Rehabilitation Group, Texas Association of Schools Boards, Texas Medical Association, Texas Medical Management, Inc., Texas Mutual Insurance Company, Texas Physical Therapy Association, Texas Physical Therapy Association, Texas Occupational Therapy Association, Inc. (TOTA), Texas Pharmacy Association, and Work & Rehab.

Summaries of the comments and commission responses are as follows:

SUBSECTION (a)

COMMENT: Commenters recommended language be added to the term "case review doctor" as defined in subsection (a) to indicate the case review doctor must be on the commission's Approved Doctor List (ADL) and to clarify that the standards for case review doctors are those found in subsection (h) of this section. One commenter further recommended that a definition for the term "majority of disputed care" be added to subsection (a), Definitions, since this term is referenced in commission rule 133.308 and is required to ensure a consistent and fair assignment of cost.

RESPONSE: The commission agrees to add the language "from the commission's Approved Doctor List" to the definition of "case review doctor." The AMDR process will benefit from the qualifications and specialized system knowledge that ADL doctors possess. Further, this addition is consistent with commission rule 180.20(a)(2), which requires doctors who provide any functions in the Texas workers' compensation system to be on the ADL. However, the commission disagrees with the need to outline standards for case review doctors as these are clearly specified in subsection (h), regarding Assignment. The commission also disagrees with the need to add a definition for "majority of disputed care" because the majority of disputed care is not a factor in determining the prevailing party under this section. The streamlined AMDR process, in subsection (n), assigns liability for the modest review fee based upon whether any disputed care is found to be medically necessary.

SUBSECTION (b)

COMMENT: Commenters support the less expensive fee to dispute claims totaling less than $650.

RESPONSE: The commission agrees and expects AMDR to provide a forum for low-dollar disputes that previously were economically unfeasible to pursue.

COMMENT: Commenter recommended that bills previously reviewed and denied by the commission's medical dispute resolution process should not be eligible for submission.

RESPONSE: The commission agrees. The prohibition contained in subsection (b)(4) prevents previously reviewed disputes in which a decision has been issued by an Independent Review Organization (IRO) or the State Office of Administrative Hearings (SOAH) from proceeding to another review through the AMDR process.

COMMENT: Commenter recommended that treatment plans be eligible for medical necessity review through the AMDR process.

Commenter also provided suggested language for an amendment to the proposed rule, permitting submission of a treatment plan outside the page limitations for document submissions.

RESPONSE: The commission disagrees with the need to add the recommended language regarding treatment plans to the rule. To the extent that a treatment plan encompasses care that has not been provided, billed, and/or denied, the care is outside the retrospective nature of AMDR. However, as the commission does not dictate what medical documentation may be submitted (other than limiting supporting documentation to five single-sided documents), the commission agrees that a treatment plan may be submitted by a requestor to support the medical necessity of the service under review.

COMMENT: Commenter stated that the consolidation of unbundled claims, where people are attempting to use the process as a way of getting sequential review at a reduced rate, will be a further burden on the commission.

RESPONSE:: The commission disagrees. The unbundling of claims and how a provider bills for services is beyond the scope of this rule. AMDR addresses the medical necessity of the disputed billed charges in a given request. A threshold determination for an AMDR request is whether the disputed billed charges exceed the tier one fee for an IRO review. The commission will not be attempting to consolidate multiple requests from a provider to ascertain if that threshold has been exceeded. Unbundling, as a fee dispute or an enforcement issue, is addressed by other commission rules and processes. Health care services that must be bundled for billing purposes must likewise be bundled for purposes of AMDR requests.

COMMENT: Commenter recommended subsections (b)(1)(A) and (B) be amended to establish a 30-day date of service range and require that all treatment rendered during that date of service range be submitted to determine if this rule would be applicable. Commenter stated the proposed language in subsection (b), in combination with language in subsections (n)(2) and (n)(3), will encourage fragmentation of a submitted dispute. Commenter further stated that when disputes on identical or similar issues within the same treatment period are pulled out of context of the more significant treatment scenario, and consecutively submitted under the AMDR process, each singular dispute is not likely to illustrate the greater impact of treatment, or lack thereof, had it been reviewed in proper context. Commenter recommended language be added to state that healthcare providers must submit all unresolved bills at one time or risk administrative violation because healthcare providers should be prevented from submitting cases for medical dispute resolution for ongoing treatment.

RESPONSE: The commission disagrees with the need to establish a 30-day date of service range. A provider may choose to consolidate bills for submission to AMDR as long the billing charges total less than the tier one fee for an IRO review, or the provider may choose to separately submit bills for AMDR review. However, the health care provider (HCP) may incur several case review fees if the HCP does not prevail in the many fragmented disputes. This should serve as an economic disincentive and limit the practice of fragmentation. The requirements regarding bundling and unbundling for billing purposes should likewise limit fragmentation. The carrier will have the full perspective of the care in dispute and other care that has been provided within a close time range. The carrier may submit this information when responding to an AMDR dispute to support its denial of payment for care on medical necessity grounds. The commission also disagrees with adding language that would penalize HCPs with an administrative violation for not submitting all unresolved bills at one time as the AMDR process is for the review of retrospective care, as stated in subsection (b)(3), and not for the prospective review of ongoing treatment.

COMMENT: Commenter recommended the term "exclusive process" be defined to clarify whether charges less than $650 can be or must be pursued through AMDR. Commenter recommended that the terms "single bill" or "multiple bills" be defined to clarify whether separate bills/services refer to services listed on separate HCFAs, or services provided on separate days, or services with different CPT codes. Another commenter recommended the commission specify what falls under this AMDR rule and clarify that the dollar amount is $650 based on the fee schedule amount and not the billed charges. Commenter included recommended language to insert "per TWCC fee schedule payment amount" into subsections (b)(1)(A) and (B).

RESPONSE: The commission disagrees a definition for the term "exclusive process" is required. Subsection (b)(1) provides that AMDR is the exclusive (only) process to resolve claim-specific retrospective medical necessity disputes for health care in which the sum of the disputed billed charges is less than the IRO's tier one fee. This is mandatory language that prohibits the filing of qualifying disputes through the IRO process of §133.308 of this title. If a dispute is for health care in which the sum of the disputed billed charges is greater than the IRO's tier one fee, the dispute must be resolved through the IRO process as stated in subsection (b)(5). The commission disagrees that the terms "single bill" and "multiple bill" need to be defined as the terms are understood to include the commission approved billing forms referenced at §134.800 of this title and may include multiple dates of service and service codes. The commission disagrees with the inclusion of the recommended language, "per TWCC fee schedule payment amount," as subsection (b) clearly specifies that billed charges are to be considered for AMDR purposes.

COMMENT: Commenter stated that it might be difficult to establish payment parameters and fees in AMDR cases where different decisions are rendered on multiple bills submitted by a requestor.

RESPONSE: The commission disagrees. The reimbursement payment parameters are established in the commission's fee guidelines, which include Pharmacy, Ambulatory Surgical Center, and Medical Fee Guidelines. The case review fee is not variable and is $100 as established in subsection (j) of this section.

COMMENT: Commenter stated the proposed rule does not effectively address the requestor who will divide an aggregate of disputed charges totaling greater than the upper limit into a multiple of smaller requests. Commenter recommends that the commission address this concern in the AMDR rule.

RESPONSE: The commission disagrees there is a need to further address the submission of disputed billed charges. The unbundling of claims and how a provider initially bills for services is beyond the scope of this rule. AMDR addresses the medical necessity of the disputed billed charges in a given request. Unbundling, as a fee dispute or an enforcement issue, is addressed by other commission rules and processes. Furthermore, once services have been billed on a claim the health care provider is prevented from later separating those billed services to fit under the IRO's tier one fee as there will already be a record of the initial disputed bill.

SUBSECTION (c)

COMMENT: Commenter stated proposed subsection (c) is unlawful as it would require a carrier to pay medical bills for treatment provided to an injured employee regardless of compensability or extent of injury issues in claims where the carrier has timely disputed the claim and that this will result in unnecessary costs.

RESPONSE: The commission disagrees proposed subsection (c) is unlawful, and further disagrees with the commenter's interpretation of subsection (c). However, comments led the commission to reconsider whether AMDR should proceed simultaneously with pending liability and or compensability disputes. The commission has determined that to economize system resources and expenses, an AMDR review will not proceed until after final adjudication by the commission finds liability and compensability for the injury. Language has been added to subsection (c)(3) to incorporate this concept. Consequently, proposed subsection (c)(4) which stated that if a carrier has disputed compensability, AMDR shall proceed to a final decision and order has been deleted. Correspondingly, subsection (c)(6) has been deleted. Therefore, medical bills for treatment are not reimbursed until compensability is established.

COMMENT: Commenters opposed subsection (c)(1) because this violates legal standards in Texas for workers' compensation law that benefits are payable only for compensable injuries, TLC 401.011, 408.003 and 408.021. Commenter states that this provision places carriers in the position of having to pay medical benefits for claims that are found to be not compensable. Commenter stated that the law does not require a carrier to pay benefits until it files a denial letter. Commenter further stated that a carrier's failure to file a notice within 15 days, subjects the carrier to administrative penalties, but does not waive the carrier's right to contest compensability. Commenter recommended the language be stricken.

RESPONSE: The commission disagrees proposed subsection (c)(1) is unlawful. Adopted subsection (c)(1) is consistent with newly adopted §124.3 of this title, regarding Investigation of an Injury and Notice of Denial/Dispute. This rule does not affect the timing of the carrier's obligation to begin payment of income benefits. The commission has determined that to economize system resources and expenses, an AMDR review will not proceed until after final adjudication by the commission finds liability and compensability for the injury. Language has been added to subsection (c)(3) to incorporate this concept. Consequently, proposed subsection (c)(4) which stated that if a carrier has disputed compensability, AMDR shall proceed to a final decision and order has been deleted. Correspondingly, subsection (c)(6) has been deleted. Therefore, medical bills for treatment are not reimbursed until compensability is established. The commission agrees that a carrier's failure to file a notice within 15 days does not waive the carrier's right to contest compensability. The commission disagrees that the language in subsection (c)(1) should be stricken from the rule.

COMMENT: Commenter requested clarification on how long the carrier has to claim that there are compensability issues for psychological services and when does the "clock start ticking."

RESPONSE: The commission disagrees that the commenter's concern is within the scope of the AMDR rule and refers the commenter to newly adopted §124.3 of this title, regarding Investigation of an Injury and Notice of Denial/Dispute.

COMMENT: Commenter recommended the deletion of the language "files a request for" in subsection (c)(3) and replace with "obtains an Interlocutory Order from." Commenter also recommended the deletion of the language, "under §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference) to dispute the carrier's denial," as adjudication of compensability in total or in part is necessary to protect the carrier and the injured employee from unnecessary accumulation of medical bills in the event a workers' compensation claim or a claim for extent of injury.

RESPONSE: The commission agrees in part and has revised subsection (c) as described above. However, the commission disagrees with replacing the text with "obtains an Interlocutory Order from." Because the revised text requires final adjudication of compensability and liability prior to an AMDR review, there is no need for interlocutory or conditional orders.

COMMENT: Commenter recommended the deletion of subsections (c)(4) and (5). Commenter also recommended amending subsection (c)(6) to include language to ensure that the carrier will be refunded the case review fee in the event of a dismissal. Commenter stated that providing this safeguard makes the issue of case review fees more balanced.

RESPONSE: The commission agrees with the recommendation to delete subsection (c)(4). The commission has determined that to economize system resources and expenses, an AMDR review will not proceed until after final adjudication by the commission finds liability and compensability for the injury. Language has been added to subsection (c)(3) to incorporate this concept. Consequently, proposed subsection (c)(4) which stated that if a carrier has disputed compensability, AMDR shall proceed to a final decision and order has been deleted. Correspondingly, subsection (c)(6) has been deleted. These deletions eliminate the issue of reimbursement of case review fees in the event of dismissals. Proposed subsection (c)(5), now (c)(4) has not been deleted because direction is needed for AMDR disputes in which issues of compensability and/or liability regarding body parts or conditions have been resolved.

SUBSECTION (d)

COMMENT: Commenters opposed the requirement of the prescribing doctor, regardless of the doctor's desire or intent, to be a "party" to the dispute if the prescribing doctor is not the health care provider who provided the care in dispute. Commenters stated that the Texas Labor Code does not provide the commission with the specific legal authority to designate a "non-party" as a "party" in a Medical Dispute Resolution proceeding. Commenters stated that §413.031(h) and (i) already determine who should be a party to a dispute and the only two parties contemplated by the statute are the individuals requesting the review and the carrier; therefore, the physician in such instances would not be a "party" and he or she could not be considered a "nonprevailing party" liable for the payment of the review fee. Commenter stated this is an inappropriate shifting of cost onto the shoulders of the physician and if the physician has not requested a review or initiated the dispute, he or she should not be a party and should have no monetary responsibility for the outcome. Commenter stated that the commission can direct non-parties to produce any and all essential medical documents without forcing the prescribing doctor to be a party. Commenter recommended the rule be amended to reflect that a non-requesting physician is not a party.

RESPONSE: The commission disagrees. The naming of the prescribing/referring doctor as a "party" to the AMDR dispute

recognizes the doctor's impact and obligations within the workers' compensation system. The obligation of the prescribing/referring doctor to provide the requisite documentation to support the medical necessity of the disputed care recognizes that this doctor is the best placed party to address the issue. The prescribing/referring doctor is required to provide, directly or through appropriate referral, that care which is medically reasonable and necessary to treat the injured employee's compensable injury. Further, the pecuniary interest assigned to the prescribing/referring doctor in subsection (n)(2) of this section gives the doctor legal standing in the dispute.

The commission disagrees that Texas Labor Code §413.031(h) and (i) already determine who should be a party to the AMDR dispute. Section 413.031(h) applies to the review fee for disputed care that requires preauthorization, and is inapplicable to the retrospective review that is AMDR. Section 413.031(i) is inapplicable to AMDR as the specific provision of §413.031(m) controls. For the reasons stated above, the prescribing/referring doctor has been assigned party status for purposes of AMDR. The rationale is particularly compelling in the case of a doctor who has prescribed medication that was either filled by a pharmacist who was denied reimbursement, or paid out-of-pocket by an injured employee who was denied reimbursement. The commission sees this as the appropriate assignment of the cost within the system, as in this instance, both the pharmacist and the injured employee had to rely on the professional judgment of the prescribing/referring doctor that the medication was medically reasonable and necessary. The prescribing/referring doctor must be accountable for his medical judgment in accordance with the Act and commission rules.

While the commission agrees that it can require any system participant to produce medical records, it disagrees that this prohibits the commission from designating the prescribing/referring doctor as a party to the AMDR dispute. Further, the prescribing/referring doctor's role in AMDR is more extensive than providing records. The doctor may elect to prepare a comprehensive summary that outlines the medical necessity of the prescribed care. For all the above reasons, the commission disagrees that the rule should be amended to reflect that a non-requesting physician is not a party. The physician's role, statutory obligation, and assigned pecuniary interest make the prescribing/referring physician a necessary party.

COMMENT: Commenters stated that there are significant flaws in the logic behind the assignment of accountability as it relates to physical therapy as no "prescribing doctor" exists in the practice of physical therapy, rather injured employee's are "referred" for physical therapy. Commenters stated that prior to initiating any care, it is the legal responsibility of the physical therapist to perform a thorough initial evaluation to determine if the application of physical therapy services is, in fact, actually indicated and that this constitutes the fundamental determinant of both reimbursability and "medical necessity" of physical therapy services under the Medicare Program. Commenter stated that physicians and others who provide physical therapy services in their own offices with unlicensed, on-the-job trained support staff, and those who have a financial interest in their own physical therapy practice will not be deterred from continuing to refer patients (to themselves). Commenter stated that in such instances, it is appropriate to assign accountability for the care to the self-referring physician.

RESPONSE: The commission agrees in part and has revised the language of subsection (d)(2) of this section to clarify that the terms prescribing doctor and referring doctor are used interchangeably for AMDR purposes. The terminology for the prescribing doctor has been changed to prescribing/referring doctor. This is also a clarification by the commission, in response to many comments from physical therapists, of its position that a doctor who prescribes medicines or refers injured employees for physical therapy (whether by specifically prescribed protocol, or by nonspecific request for evaluation and treatment) is a necessary party for AMDR purposes. Those purposes include providing documentation supporting the medical necessity of prescribed/referred care and being accountable for reimbursement of the $100 review fee in the event that a prescription to a pharmacy or durable medical equipment provider is found to be not medically necessary.

The commission agrees it is the responsibility of the physical therapist to perform an initial evaluation and determine if the injured employee will benefit from physical therapy services. If a physical therapist determines that an injured employee will not benefit from physical therapy services, then the physical therapist should elect not to perform the services thereby avoiding disputed charges based on their own evaluation. Nevertheless, it is the commission's position that the prescribing/referring doctor's referral to physical therapy determines the medical necessity of the services, and therefore, the prescribing/referring doctor is held responsible for providing any necessary supporting documentation if requested by a physical therapist. However, in response to public comment, the commission has changed the rule to require a requestor (including physical therapists) to initially pay the case review fee, but in the event the requestor does not prevail, unlike in the case of pharmacies or durable medical equipment providers, the prescribing/referring doctor will not reimburse the case review fee to a physical therapist. This change in the rule was made to address the concerns of physical therapists regarding their perceived loss of outside referrals from prescribing/referring doctors arising from the doctor's liability for the case review fee in the rule as proposed.

The commission disagrees with commenter's assessment that physicians and others who provide physical therapy services in their own offices with unlicensed, on-the-job trained support staff, and those who have a financial interest in their own physical therapy practice will not be deterred from continuing to refer patients (to themselves). It is not the commission's intent, through adoption of AMDR, to deter any referrals for medically necessary care, whether in-house or to outside, independent physical therapists. The commenter stated that only in cases of self-referrals is it appropriate to assign the accountability for the care to the referring physician. The commission, however, disagrees with making this exception in the rule for the reasons stated above regarding the responsibility of the prescribing/referring doctor for the medical necessity of prescribed care.

COMMENT: Commenter recommended the proposed rule be amended to state that a representative of the prescribing doctor must be present if the prescribing doctor is unable to attend the AMDR as the proposed rule requires the prescribing doctor be present at the AMDR and that this will further increase doctors' administrative overhead.

RESPONSE: The commission disagrees, as the AMDR process is a review of medical records and documentation only. AMDR is not a formal hearing that requires the presence of the disputing parties in order to resolve the dispute. To the contrary, subsection (l)(3) of this section prohibits any communication between parties and the case review doctor to avoid undue influence.

Consequently, the effect on the doctor's administrative overhead is minimized.

COMMENT: Commenter recommended amending subsection (d)(4) by deleting the language ". . .and shall not be considered a requesting party" and including language that affords a carrier the right to also participate as a requesting party. Commenter stated that the rule as proposed leaves the carrier with no recourse for requesting refunds that would otherwise fall under the rule proposal. Commenter further stated that proposed subsections (n)(2) and (n)(3) ensure the carrier will ultimately be responsible for most fees; therefore, carriers should also be afforded equal rights to gain benefit from this rule. Commenter stated that §133.307(b)(3) affords the carrier rights as a requesting party in regard to the carrier's refund request, and §133.309 should also provide an equivalent standard.

RESPONSE: The commission disagrees with the recommendation to amend the language of paragraph (d)(4) to allow a carrier to be a requesting party. AMDR pertains to issues of retrospective medical necessity, not fee disputes. Consequently, refunds (reimbursements) under AMDR are not analogous to requesting refunds for care previously paid for under §133.307(b)(3) of this title. Refunds (reimbursements) under AMDR are limited to case review fees pursuant to paragraphs (n)(2) and (3). The adopted changes to subsection (j) eliminate the carrier's need to request refunds (reimbursement) as the carrier now pays the initial case review fee only when the requestor is an injured employee. Accordingly, the commission disagrees that §133.309 requires an equivalent provision to that found in §133.307(b)(3) of this title.

SUBSECTION (e)

COMMENT: Commenter recommended the language "may be submitted after exhaustion of the reconsideration process as established in §133.304 of this title (relating to Medical Payments and Denials) and" be added to subsection (e)(2) to make the injured employee equally responsible for following the standard process of resolving disputed issues. Commenter stated that requiring the injured employee to request reconsideration under §133.304 encourages resolution of disputes between the carrier and the injured employee without the commission's involvement and that the explanation of benefits outlines the steps the injured employee needs to follow if the injured employee disagrees with the carrier's decision.

RESPONSE: The commission disagrees with adding the recommended language that an injured employee be required to follow the reconsideration provision under §133.304 of this title. The commission's provision at §133.304(k) of this title does not allow the injured employee a quick resolution in obtaining reimbursement for out-of-pocket expenses. Requiring an injured employee to request reconsideration results in an approximate 70-day delay before even requesting AMDR, and this delay places an undue strain on the injured employee. Additionally, an injured employee's access to medical documentation is limited and a request for reconsideration will not likely result in a change to the carrier's original denial of payment, effectively prolonging the injured employee's ability to seek relief.

SUBSECTION (f)

COMMENT: Commenters opposed the requirement that the prescribing doctor provide documentation supporting the medical necessity of the service in dispute. Commenters stated that while cost efficient reviews and resolution of medical necessity disputes are important, the review of the records, the medical expertise, and the time to create a new three page summary for AMDR may well cost more than the disputed charges, and that this imposes an increased administrative burden on the referring physician who may not even be the physician requesting the dispute and who has no discretion as to whether a dispute is even to be filed. Commenter stated that the $100 "fine" and three page summary subjects the prescribing doctor to an administrative sanction when that doctor hasn't even filed a dispute and is not a party thereto. Commenters stated that even if medical necessity were upheld, it would be a pyrrhic victory for the prescribing doctor if not the requestor of the dispute because no matter who wins, the prescribing doctor does not get paid for this service. Commenter stated the commission by rule creates an unfunded mandate, which is borne by the physician. Commenter stated that the administrative burden would dissuade physicians and surgeons from making referrals, which will both hurt physical therapists and undermine the quality of care workers need to fully recover. Commenter stated this appears to be yet one more method whereby the commission, acting on behalf of the carriers, is attempting to reduce the quality of care available to Texas injured workers and punish the physician. Commenter stated this would invite carriers to destroy doctors and physical therapists by attrition, forcing each claim into dispute. Commenters recommended the deletion of the language that requires the prescribing physician to submit medical documentation or, at the least, be accompanied by a rule that requires a non-prescribing health care provider to pay the prescribing physician a reasonable cost for the production of the medical records or the three page medical summary.

RESPONSE: The commission disagrees with the commenter's opposition to the requirement that the prescribing doctor provide documentation supporting the medical necessity of the service in dispute. The prescribing doctor has determined that care is necessary by nature of the referral and will therefore, have the medical documentation to support the basis for the determination. The commission disagrees that there will be an increased administrative burden on the referring physician since the referring physician is not required to summarize the medical documentation but may opt to provide existing medical records to the requestor. The requestor may choose to summarize the medical records or include some of the medical documents as long as the page limit is adhered to. The commission disagrees the prescribing doctor should not be a party to the AMDR dispute as previously stated in response to comments to paragraph (d)(2) above. Even more fundamentally, the prescribing doctor's referral initiated the medical care that is subject to dispute. The commission recognizes that pharmacies and durable medical equipment providers do not have the option to evaluate and treat as is afforded physical therapists who have the option to avoid delivering unnecessary services. Consequently, the commission has determined that liability for the case review fee shall only remain with the prescribing doctor in the case of prescriptions for pharmacy and durable medical equipment services, and not when the doctor has prescribed/referred physical therapy or any other health care service. This change in the rule was made to address the concerns of physical therapists regarding their perceived loss of outside referrals from prescribing/referring doctors arising from the doctor's liability for the case review fee in the rule as proposed. The commission disagrees with commenters who have characterized the assignment of liability for the case review fee a "fine" on the prescribing doctor. The nominal review fee is properly assessed to the prescribing doctor for pharmacy and durable medical equipment services while other nonprevailing requestors will remain liable for the case review fee. The adopted rule is expected to ensure that prescribed care will be

carefully considered, while resulting in a reduction of care that is not truly necessary due to the potential liability of the case review fee. Although the prescribing doctor is not reimbursed for providing the medical documentation in an AMDR dispute, the administrative cost for providing the limited documentation is nominal. Consequently, the commission disagrees this rule creates an unfunded mandate and an administrative burden on the prescribing doctor. The commission does not agree with commenter's assertion that this nominal cost for documentation production will dissuade physicians and surgeons from making necessary referrals, thereby hurting physical therapists and undermining the quality of care that workers need to fully recover. AMDR may create a check on unnecessary referrals that can actually delay an injured employee's recovery, while proper referrals for medically necessary care are expected to continue to the benefit of injured employees in Texas. The commission strongly disagrees that it is acting on behalf of carriers as the adopted rule provides an opportunity for injured employees and HCPs to address the recovery of costs, which heretofore could not economically be recovered. The commission strongly disagrees that this adopted rule is another method to reduce quality of care available to injured employees and punish referring physicians. The adopted AMDR rule places more accountability for prescriptions and referrals, and should serve as a tool to improve the quality of care by reducing frivolous care, which may extend and prohibit an injured employee's ability to return to work. With the adopted changes regarding the prescribing/referring doctor's liability for the case review fee, the commission disagrees the AMDR rule invites carriers' destruction of doctors and physical therapists by forcing each claim into dispute. The adopted AMDR rule allows for low-dollar disputes, with a nominal case review fee, to have a forum and process that was not previously available. AMDR is consistent with the commission's mandate to control system costs while maintaining quality of health care for injured employees. Based upon the above stated reasons, the commission disagrees with the recommendations to delete the requirement of the prescribing doctor to submit medical documentation for ADMR and to reimburse the prescribing doctor a cost for the production of these medical records and/or summary.

COMMENT: Commenter recommended amending the documentation requirement in subsection (f)(2) to allow for a summary and 10 additional pages. Commenter stated that this is supported by the health care industry concept that medical records should stand on their own and that a written summary, alone, by either party is not verifiable without the appropriate corresponding medical records. Another commenter stated that a three-page summary may not be sufficient to establish medical necessity for a particular patient. Commenter stated that as proposed, the rule increases the probability that limited information could be pulled out of a proper context. Commenter recommended the proposed rule include any documentation that indicates that preauthorization or voluntary certification was previously obtained from the carrier.

RESPONSE: The commission disagrees with the recommendation to allow for a summary and 10 additional pages. However, subsection (f)(2) has been amended to allow for two additional pages of documentation. Subsections (g)(4), (k)(2) and (l) have been similarly amended. Language has also been added to indicate that the documentation may include a summary that will be counted toward the five single-sided documents allowed by the amended language. The commission agrees that the medical documentation should stand on its own. Therefore, a disputing party may choose to send medical documents only, without a summary. And, even though a summary may not be verifiable, any misrepresentation of a summary will be considered fraud and the commission will take appropriate action. While all cases are unique, the expanded documentation limit should enable doctors to support the medical necessity of low-dollar treatments and services. While not agreeing to any amendment of rule language, the commission agrees that a disputing party can and should provide documentation in the request for AMDR that indicates preauthorization or voluntary certification was previously approved from a carrier. This will assist the commission in determining what services were preauthorized and what services were not, thereby avoiding a case review of any preauthorized services. In addition, if the supporting preauthorization/voluntary certification indicates all of the services in dispute were preauthorized, the request will not proceed to the case reviewer, the carrier will be ordered to reimburse the preauthorized/voluntary certification services and will also be referred to the commission's Compliance and Practices Division for violation of §133.301(a) of this title.

COMMENT: Commenter stated that the commission will likely find itself necessarily increasing its staff to "facilitate compliance" of the prescribing doctors to provide required documentation to the requesting HCP, which will cause an increased fiscal impact. In the extreme, this requirement could lead to litigation among the parties and the commission. Commenter stated that case reviewers will be faced with a three-page limitation, which may not be sufficient records, causing contact of the parties for more information. Commenter stated the rule penalizes the prescribing doctor with exposure by requiring a three-page summary. Commenter further stated that a case review opinion rendered from non-original records would likely cause issues of legitimacy to be raised and the opportunity for challenge is created by being sued.

RESPONSE: The commission disagrees in part. The commission agrees the overall AMDR process will require additional commission resources which will increase fiscal impact. However, the need to facilitate compliance for prescribing doctors that do not submit the required documentation will be handled through enforcement actions by the Compliance and Practices Division; therefore, this issue will not result in increased fiscal impact and will only marginally increase opportunities for litigation related to an enforcement action. The commission agrees more documentation may be necessary and has amended subsections (f)(2)(D), (g)(4), (k)(2) and (l) to allow submission of five single-sided documents, which may include a summary. In order to maintain case reviewer independence, contact with the parties is not allowed by the rule pursuant to subsection (l)(3). The AMDR process was created to resolve low-dollar disputes, and therefore, the amount of documentation needed to support medical necessity should not be voluminous. The revised page limit should adequately meet the case review doctor's needs. The commission disagrees the rule penalizes the prescribing doctor with exposure by requiring a three-page summary as the submission of a summary is an option of the requestor and is not required of the prescribing doctor. The commission disagrees that a case review opinion rendered from non-original records will likely cause issues of legitimacy to be raised. Adding to the legitimacy of decisions rendered on the provided documentation is the fact that any misrepresentation of a summary will be considered fraud and the commission will take appropriate action.

Lastly, while any new commission process creates the potential for litigation, there is an economic disincentive for initiating litigation over low-dollar disputes.

COMMENT: Commenter asked who is going to determine where the three-page summary came from and whether a doctor will rely on somebody else's paraphrasing of his original record.

RESPONSE: The commission clarifies that the commission will assume that the documentation submitted in a dispute is from one of the parties in a dispute, including the referring doctor if applicable. The commission will not be involved in verifying where the documentation originated other than verifying that the documentation was submitted by a party to the dispute. If a referring doctor is named as a party to a dispute, then the requestor will be responsible for incorporating the documentation provided by the referring doctor into the five-page maximum allowable information for review. Any fraudulent misrepresentation committed by a requestor will be addressed by the commission's Compliance and Practices division.

SUBSECTION (g)

COMMENT: Commenter stated that sending the three page summary to the injured employee destroys any semblance of maintaining a chain of custody for the only record to be used to determine medical necessity in an AMDR case.

RESPONSE: The commission disagrees that by sending the supporting documentation to the injured employee it will destroy the chain of custody for the record used to determine medical necessity in an AMDR case. This comment is in reference to subsection (g) which outlines requests for AMDR submitted by an injured worker and specifically paragraph (4) of (g) which describes the documentation supporting the medical necessity of the care in dispute. If the injured employee has incurred out-of-pocket expenses for health care and the carrier has denied the care as not medically necessary, then it is the employee's right to seek AMDR and to gather the medical records and documentation to support the dispute request. A check on the accuracy of records submitted by the requestor is provided by the carrier's submissions, which come after the commission has provided a copy of the request to the carrier in accordance with subsection (i)(2). The case review doctor's decision is not based upon the requestor's submission alone. Again, any fraudulent misrepresentation committed by a requestor will be addressed by the commission's Compliance and Practices division.

SUBSECTION (h)

COMMENT: Commenter recommended the commission maintain a list of doctors interested in AMDR case review separately as not all designated doctors may be interested in this additional paperwork. Commenters recommended the case review doctor be on the commission's ADL and the license and scope of practice should be listed in the respective doctors' Occupation Code sections. Commenter recommended the term "appropriate qualifications" in subsection (h) be defined as it will create ambiguity.

RESPONSE: The commission agrees in part that case review doctors should not be required to be on the Designated Doctor List. The specialized training that designated doctors possess is not at issue in an AMDR review. Designated doctors may elect to participate as AMDR case review doctors, but participation only requires ADL status. Accordingly, the commission has added the language "the commission's Approved Doctor List" to the definition of "case review doctor" in subsection (a) of this section. The commission's intent was to use ADL doctors because these doctors have been approved by the commission to participate in the workers' compensation system based upon their training and specialized knowledge of the system. This addition will clarify this intention. The commission disagrees that the term "appropriate qualifications" needs to be defined, or rather, further defined. In actuality, the term is defined by paragraph (1) of subsection (h) wherein the selected doctor will be of the same or similar licensure as the prescribing/referring or performing doctor.

COMMENT: Commenter stated that using doctors on the ADL repeats the mistakes of the former MDR process and that the IRO process protects the reviewing doctor.

RESPONSE: The commission disagrees that using doctors on the ADL is a mistake and although the IRO process does not reveal the reviewing doctor's identify, the IRO reviewers are still required to be on the ADL.

COMMENT: Commenters opposed doctors providing case review and deciding the "medical necessity" of the physical therapy care in dispute and the proposed rule's principal of "peer review" appears to exclude physical therapists. Commenters stated that this is inappropriate, unfair, and unwise for the same reasons that physical therapists receive "referrals" rather than "prescriptions." Commenters stated that chiropractors should not review physical therapy services. Commenters stated that case review doctors are not physical therapists and do not have a same or similar licensure as a physical therapist and will likely lead to fewer resolutions. Commenter stated that a legal authorization to practice in any field of medicine does not always translate to competence in a particular area and that this review flaw is likely to lead to mistakes by the reviewer and undercuts the effectiveness of the proposed dispute resolution system. Commenter stated the very nature of true peer review indicates that a practitioner from the same profession should conduct the review. Commenter stated that for a case review to be valid there must be a review from a reviewer who is both neutral and a genuine peer and that this rule does not provide adequate explanation as to what constitutes a "peer." Commenters recommended amending the language in subsection (h)(1) to require the case reviewer be of same licensure as the licensed health care provider directly performing care to the injured employee. Commenters recommended the rule require that the case reviewing doctor be actively practicing medicine and actively practicing in the same or similar specialty, or at least be a natural fit, an orthopedic surgeon should review the cases of other orthopedic surgeons and not ophthalmologists or dermatologists. Commenters recommended the AMDR process be a true peer review process and stated that the American Physical Therapy Association defines a peer review as a peer of like-minded and profession; therefore, the AMDR review of physical therapy should be performed by licensed physical therapists. Commenter recommended that physical therapists desiring to serve as case reviewers should be required to go through commission training similar to designated doctors.

RESPONSE: The commission disagrees that doctors should not perform the case review of physical therapy services as physical therapy treatment is initiated by a doctor's prescription/referring that determines the medical necessity of the service. Doctors are better situated to review not only the appropriateness of specific treatments rendered, but the medical necessity for physical therapy generally as it relates to the compensable injury and the recovery of the injured employee. The commission has amended subsection (d)(2) by expanding the terminology to

read, "prescribing/referring doctor..." based on commenter's differentiation of the terms, and the commission agrees both terms are appropriate. However, the commission clarifies that it uses both terms interchangeably for AMDR purposes as the commission holds the prescribing/referring doctor accountable for the medical treatment and services prescribed/referred for the injured employee. An ADL doctor of same or similar licensure will be called on to perform a case review to determine medical necessity, enhancing, not undercutting the resolution of AMDR disputes. Neutrality of the reviewer will be maintained by adherence to the provisions of subsections (h)(2) and (3) regarding conflicts of interest and prior treatment of the injured employee whose treatment is at issue. Regarding concerns raised that chiropractors should not review physical therapy services, the commission clarifies that several types of ADL doctors (e.g., M.D., D.O., or D.C.) may appropriately review physical therapy services. Assignments will be determined on a case-by-case basis. For these reasons, the commission disagrees with the recommendation to amend the language in subsection (h)(1) to require the case reviewer be of the same licensure as the health care provider performing the service. ADL doctors will be selected from an area of practice that is of the same or similar licensure as the prescribing/referring or performing doctor. Additionally, while most ADL doctors maintain an "active practice," such a requirement is only expected of designated doctors in the system. Consequently, the commission will not further restrict the requirements for the case review doctor by amending rule language to require "active practice." Lastly, for all the above reasons, the commission disagrees to amend the rule to permit physical therapists to conduct reviews of physical therapy services. While it may be appropriate to institute training of physical therapists, the commission further disagrees with the recommendation to provide commission training to physical therapists for this purpose at this time.

COMMENT: Commenter recommended further clarification be added to subsection (h), regarding Assignment, because there is the possibility that an injured employee or health care provider may find that a case review doctor has a potential conflict, bias, or financial interest that could jeopardize their neutrality and/or objectiveness. Commenter stated that this is especially of concern since AMDR disputes are not subject to either administrative or judicial review. Commenter further stated that if the health care provider is from a smaller township with limited approved doctors, then greater chances of abuse exist if the carrier uses the local doctors for Required Medical Examinations and peer review purposes. Commenter stated that the commission's choice of case review doctor is not an unbiased third party.

RESPONSE: The commission disagrees further clarification regarding potential conflict, bias, or financial interest is needed in subsection (h). If an assigned case review doctor cannot meet the requirements of subsections (h)(2) or (3), the commission's process will direct the case review doctor to immediately notify the commission for case re-assignment to a new case review doctor. Also, case review doctors will be from all areas of the state and will not be restricted to local geographical areas. The commission disagrees that case review doctors assigned by the commission, who meet the requirements of subsections (h)(2) and (3), are not unbiased third parties.

SUBSECTION (i)

COMMENT: Commenters recommended the requesting party should be responsible for payment of the review fee at the onset of the process. Commenter stated that since the rule is designed to be an affordable, lower cost dispute alternative, then the requestor should be responsible to the pay up front cost. Commenter stated that requiring the carrier to pay the initial fee would encourage the filing of thousands of disputes regardless of the amount(s) in dispute.

RESPONSE: After consideration of public comment, the commission agrees not to require the carrier to pay the initial case review fee. Subsection (i) has been changed from proposal to require the requesting party, other than the injured employee, to pay the case review fee at the onset of the process. This is expected to discourage the filing of frivolous disputes.

COMMENT: Commenter requested subsection (i)(3) be deleted because disallowing withdrawal discourages resolution between the parties, which is ultimately the most cost-effective solution. Commenter further stated that withdrawals are not prohibited in §133.307, regarding Medical Dispute Resolution of a Medical Fee Dispute, and §133.308, regarding Medical Dispute Resolution by Independent Review Organizations.

RESPONSE: The commission disagrees with the commenter's recommendation to delete subsection (i)(3). On the contrary, the commission encourages resolution prior to initiating the AMDR process. However, at the point of a request for AMDR, the parties have had sufficient opportunity to resolve the issues. HCPs have already been denied upon reconsideration by the carrier. Commenter and the commission recognize that withdrawals are not prohibited in §133.307 and §133.308, and because it is misused in the IRO process, it results in unnecessary use of time and resources (i.e., not cost-effective) for all parties including the commission, and therefore, it is not a viable option for this expedited process.

SUBSECTION (j)

COMMENT: Commenters supported the $100 case review fee as being a reasonable amount. Commenter stated that this will discourage frivolous disputes by healthcare providers and unethical payment disputes by carriers. Commenter stated that this fee is an excellent motivational tool for designated doctors.

RESPONSE: The commission agrees as the AMDR process is designed to resolve medical necessity disputes with a case review fee of $100. It is also designed to provide an avenue to resolve low-dollar disputes and discourage frivolous disputes and denials. The commission clarifies that amended subsection (a)(1) requires that a case review doctor be on the commission's ADL, and designated doctor status is not the requirement.

COMMENT: Commenter recommended the deletion of the case review fee. Commenters recommended the rule be amended to reflect that a non-requesting prescribing physician is not responsible for the case review fee.

RESPONSE: The commission disagrees to delete the case review fee, as the review fee is statutory. The enabling statute provides that the case review fee shall be paid by the nonprevailing party. The commission agrees in part that the prescribing/referring doctor should not always responsible for the case review fee. Subsection (n) has been changed from proposal to only require the prescribing/referring doctor to reimburse the nonprevailing pharmacy or durable medical equipment provider. The commission has determined that ultimate liability for the case review fee for dispute regarding pharmacy and durable medical equipment services should remain with the prescribing/referring doctor as that doctor should be accountable for prescribing care that is not medically necessary, which adds cost to the system.

COMMENT: Commenter recommended the injured employee not be allowed to submit AMDR requests on behalf of a healthcare provider.

RESPONSE: The commission clarifies an injured employee is not allowed to submit AMDR requests on behalf of a health care provider. An injured employee may only access the AMDR process if he/she has incurred out-of-pocket expenses.

COMMENT: Commenters opposed the $100 fee for a case review as this amount would barely cover the cost of the review of records and would not be sufficient to induce quality reviewers.

RESPONSE: The commission disagrees. The AMDR case review will consist of a review of a limited amount of documentation (10 total single-sided pages) and the $100 fee is sufficient for this type of review. The commission has conducted an informal survey of ADL Level 2 Doctors in order to gauge potential case reviewers based on the $100 case review fee and a significant number of respondents have indicated that the fee is adequate.

COMMENT: Commenters oppose the requirement that the carrier initially pay for the case review fee. Commenter stated it would be difficult to recoup these fees from the HCP and the time and expense would render the process of recouping fees impractical. Commenter stated the provision is unfair and bad policy because it encourages HCPs and injured employee's to file for AMDR, even when their position is dubious. Commenter stated that if a healthcare provider truly believes the service at issue is medically necessary, the HCP should be more than willing to pay the initial $100 for the review and this will serve as an affirmation of both the sincerity of the applicant in the necessity of treatment and the inability of the parties to resolve the issue without formal resolution. Commenter stated that neglecting to make all requesting parties equally responsible for the AMDR fees only encourages a larger volume of disputes, which seems in conflict with the goal of decreasing the overall number of disputes. Commenters stated the greatest danger of the proposed AMDR system is the potential of abuse by HCPs and injured employees in a manner to force carriers to pay for medical treatment that is unnecessary and inappropriate as it will be cheaper to pay than to dispute. Commenter stated carriers should not be the only participant to pay for the cost of the new system. Commenters recommended language be amended to require the healthcare provider to initially pay for the dispute, including an injured employee's dispute. Commenter stated that making the prescribing doctor responsible for ensuring the injured employee is receiving appropriate treatment and also responsible for any ensuing disputes regarding that treatment is supported by §408.021(c).

RESPONSE: After consideration of public comment, the commission agrees not to require the carrier to pay the initial case review fee. Subsection (j) has been changed from proposal to require the requesting party, other than the injured employee, to pay the case review fee at the onset of the process to ensure that all parties are equitably vested in the process. This is expected to discourage the filing of frivolous disputes, but is not expected to undermine the purpose or intent of AMDR, which is to efficiently obtain a professional judgment on medical necessity at a nominal cost. However, the commission disagrees the HCP should be responsible for an injured employee's case review fee and this still remains the carrier's responsibility. This provision is consistent with other commission medical dispute resolution rules and is in compliance with the statute. For the reasons stated above, the commission also disagrees carriers will be economically forced to pay for medical treatment that is unnecessary and inappropriate. The changes to subsection (j) have eliminated the carrier's need to recoup the case review fee from the HCP and ensure that carriers are not the only participants to pay for the cost of the new system. Additionally, the statute provides that the nonprevailing party is ultimately responsible for the case review fee. The commission agrees the prescribing/referring doctor is responsible for ensuring the injured employee is receiving appropriate treatment, and therefore, will also be liable for the case review fee for disputes regarding pharmacy and durable medical equipment services that are determined to be not medically necessary.

SUBSECTION (k)

COMMENT: Commenters oppose the carriers' seven-day timeframe to respond to an AMDR dispute. Commenter stated the timeframe is too short for the parties to reasonably comply. Commenter stated there is no reason to require a seven-day response for low-dollar retrospective medical necessity disputes as the requestor has had one year from the date of service to consider and prepare their dispute. Commenters recommended a 14-day timeframe, as in retrospective medical necessity disputes.

RESPONSE: The commission agrees and subsection (k) has been amended to extend the response timeframe from seven to no later than 14 days.

COMMENT: Commenter recommended the deletion of subsection (k)(1), as this recommendation is made in accordance with another comment recommendation in subsection (j)(2), which recommends the requesting party pay the case review fee, and not the carrier.

RESPONSE: The commission disagrees with the recommendation to delete subsection (k)(1). However, in accordance with the commission's changes to paragraph (j)(2), paragraph (k)(1) has been amended to apply only when the requestor is the injured employee. This provision is consistent with the commission's decision to require requesting parties, other than the injured employee, to initially pay the case review fee.

COMMENT: Commenters opposed the documentation limitation of three pages as this is reasonable for a general response but some cases require more to determine that the treatment was not medically necessary. Commenter stated that the CMS coverage policy for electrodiagnostic testing is 28 pages and eight pages for synvisc injections. Commenter recommended to amend the language to allow 10 additional pages in addition to a three-page summary, because as proposed, the rule limits the amount of medical documentation allowed in this process and this is also supported by the healthcare industry concept that medical records should stand on their own.

RESPONSE: The commission agrees that three pages of documentation may not be sufficient and, therefore, subsections (f)(2)(D), (g)(4), (k)(2), and (l) have been amended to allow submissions of a maximum of five single-sided documents by the requestor and the carrier. The commission clarifies that medical documentation need not include entire CMS policies or complete medical records because the AMDR is designed to facilitate the timely resolution of low-dollar disputes. Increasing the documentation requirements more than the adopted five-page limit would require additional time and expense and impair the cost effectiveness of the AMDR process.

COMMENT: Commenter recommended that case reviewers should be required to consider CMS coverage policies, as the IROs are required to do.

RESPONSE: The commission agrees that CMS coverage policies should be considered in relation to all commission rules and the requirements of the Act. However, as expressed in the Act and other commission rules, medical necessity always prevails.

SUBSECTION (l)

COMMENT: Commenters supported the three-page limit of documentation to be submitted for independent review as this could resolve innumerable disputes and free up the system. Commenter also supported the 30-day timeframe resolution.

RESPONSE: The commission agrees in concept that the AMDR process is designed to facilitate the timely resolution of low-dollar disputes. However, based on recommendations provided, the commission has reconsidered the three-page limit and has allowed for an adopted five-page limit for each party. Additionally, the commission has also considered the recommendations for carrier response timeframe and has increased the carrier response timeframe from seven to 14 days in subsection (k). These combined factors will slightly increase the overall timeframe for AMDR resolution.

COMMENT: Commenters opposed the three-page limit on documentation to be submitted for the AMDR case review. Commenters stated this limitation is unrealistic and will result in case review doctors not having all the relevant and essential portions of the injured employee's medical records to make an informed opinion which will result in incorrect determinations and the credibility of the whole process will be undermined. Commenter stated the summary documentation may contain the HCP's interpretation, and the HCP would be free to pick only documentation that support his viewpoint and ignore other's examinations. Commenter recommended the submission of all medical records be allowed. Commenter stated this violates TDI public standards for independent review of workers' compensation related medical treatment and services. Commenter stated the AMDR process will unintentionally authorize more inappropriate medical treatment, leading to more medical costs absorbed by employers, and may prevent prompt return to work.

RESPONSE: The commission agrees with commenters' suggestions that the three-page limit on documentation may not be sufficient for an AMDR case review and has adopted a five single-sided page limit. A summary document may be submitted as part of the five single-sided pages but is not required. Each party is allowed to select the documentation that supports their position and the case review doctor is required to consider both positions in determining medical necessity. The commission disagrees for reasons previously stated that the submission of all medical records be allowed. A check on the accuracy of records submitted by the requestor is provided by the carrier's submissions, which come after the commission has provided a copy of the request to the carrier in accordance with subsection (i)(2). The commission disagrees that this rule violates TDI public standards for independent review of workers' compensation related medical treatment and services because §413.031(m) of the Act was specifically amended to enable the commission by rule to create an alternate medical dispute resolution process (e.g., non-IRO). The commission further disagrees that the AMDR process might unintentionally authorize inappropriate medical treatment, causing increased employer costs and preventing prompt return to work because these disputes are retrospective reviews of care that has already been provided. Previously, HCPs with low-dollar disputes denied for medical necessity had no cost effective means for resolution and, consequently, HCPs were essentially writing off unpaid medical bills. This adopted rule now provides a cost effective process for resolution of such concerns, and since this is retrospective review of care, the review will determine whether the care that was provided is deemed medically necessary, and if it should therefore be reimbursed. The commission disagrees that the adopted rule will unintentionally authorize more inappropriate medical treatment. AMDR provides an efficient determination on medical necessity by commission-selected ADL doctors who will be monitored by the commission for the quality of their decisions.

COMMENT: Commenter recommended the commission reevaluate the proposed disclosure of the identity of the AMDR case review doctor. Commenter stated the IRO experience is that any disclosure of reviewer identity has a chilling effect on the quality of the review and on the willingness of qualified practitioners to volunteer as reviewers.

RESPONSE: The commission disagrees that disclosure of the case reviewer's identity and possible implications from disclosure will be problematic. Independent review organization confidentiality standards are not being applied in the adopted rule process because §413.031(m) of the Act was specifically amended for a provision, by rule, allowing for an alternate medical dispute resolution process (e.g., non-IRO). The case reviewer's identity must be known in order to establish an expedited process for filing and responding to a dispute in a timely manner. The strict safeguards adopted at subsection (l)(3) will prevent undue influence on the reviewer. The case reviewer's identity will be known and should not jeopardize the quality of the review or the willingness of qualified providers to perform this service for a fee.

SUBSECTION (m)

COMMENT: Commenter recommended a seven day timeframe for the case review doctor to issue the AMDR report as the proposed timeframe of five days is too short for the parties to reasonably comply and will create an unnecessary burden.

RESPONSE: The commission disagrees with the recommendation to increase the timeframe a case reviewer has to complete a review and issue a report from five days to seven days. The intent of the AMDR process is for an expedited review and the limitation placed on the documentation that may be submitted for review supports this expedited process by ensuring that a case reviewer can complete a review and issue a decision within five days.

COMMENT: Commenter recommended an additional $50 fee be issued to the case review doctor for the summary report.

RESPONSE: The commission disagrees at this point that the $100 review fee should be increased by $50. Due to the limited amount of documentation that a case reviewer will have to review in order to make a determination of medical necessity, the $100 fee should be adequate. The case reviewer will not be required to complete a lengthy summary necessitating an increased fee.

COMMENT: Commenter recommended that the case review doctor list in the report not only the screening criteria used but also any peer review journal articles or similar materials as the use of peer reviewed information lends credibility to the case reviewer and helps to establish the appropriate level of care. Commenter stated that a direct benefit of this approach would be a better acceptance of the AMDR system. Commenter recommended the report include screening criteria used, reviewer

qualifications, assumptions made during the review, and any and all materials or input relied upon by the reviewer.

RESPONSE: The commission agrees in part. Subsection (m)(1)(A) states the report must include "the specific reasons for the case review doctor's determination, including the clinical basis for the decision." Subsection (m)(1)(B) states the report must include "a description of, and the source of, the screening criteria that were utilized." These provisions would encompass journal articles, any similar materials, and specific reasons (i.e., assumptions) that were used to establish the clinical basis for the medical necessity decision. However, the rule does not specifically dictate every possible reference used or assumption drawn from the source material. Furthermore, the rule language is consistent with requirements for decisions rendered by IROs in accordance with §133.308(p)(1) of this title.

COMMENT: Commenter opposed language in subsection (m)(3) regarding parties to the dispute not having a right to clarification, as this is unfair to HCPs and carriers alike when the decision is ambiguous or questionable. Commenter stated that the rule indicates that the commission can direct the details and determination of the report and that such direction or result may not be related to appropriate clinical determinations of medical necessity as, in effect, the commission can order a desired result and this ability would undermine the confidence in the AMDR system and vitiate the usefulness of the case review doctor. Commenter stated the commission should not be allowed to determine who has due process in seeking clarifications. Commenter recommended the rule be amended to delete this provision or, in the alternative, list the exact circumstances by which the commission will seek a clarification and require an amended report. Commenters recommended adding language that ensures a clarification process that may be initiated by all parties, including timeframes, as this would provide a check and balance system for the clarification process. Commenter stated there is no other mechanism to hold the case review doctor accountable for addressing all required elements in subsection (m)(1). Commenter recommended the commission should also take proactive steps to ensure a process and reasonable timeframe for the filing and receiving of such clarification. Commenter recommended changing the timeframe the case review doctor has to comply with a request for clarification from three to five days as the proposed timeframe is too short to reasonably comply with and is unnecessarily burdensome.

RESPONSE: The commission disagrees with the recommendation to allow parties to seek clarification directly from the case review doctor or to request the commission seek the clarification on their behalf. The commission agrees that there is not a stated mechanism in the rule to hold the case review doctor accountable. However, the commission's intent is to review and monitor the case review doctors' reports to ensure that all relevant issues are addressed and required elements in subsection (m)(1) are met; yet, the commission will not direct the details and determinations of the case review reports. If a case review doctor fails to meet the requirements and expectations of a case review doctor, the commission will no longer use the doctor in the AMDR process. The AMDR process is designed to be an expedited process, and if an allowance was made for such clarifications by the parties, then this would result in unnecessary delays. In addition, the commission recognizes that this expedited AMDR process is also designed to be accomplished with a nominal case review fee and unnecessary communications with the case review doctor could impede the intent of this alternate dispute process. The commission disagrees that by not allowing the parties to request clarifications, the parties' rights to due process are bypassed. Due process rights are proportionate to the interest at stake. The legislature gave the commission great latitude in carving out an alternate dispute resolution process for low-dollar disputes. The commission has determined, through this adoption, that the appropriate level of due process for low-dollar disputes does not include a right to clarification. The commission disagrees with deleting this provision, or adding language that lists the exact circumstances by which the commission will seek clarification or changing the timeframe that a case review doctor has to respond to a request for clarification. The commission does not anticipate seeking clarification upon receipt of decisions but needs the flexibility to seek clarification on an as needed basis to address unforeseen circumstances, which is why the adopted rule contains this provision. The commission will not be directing or determining the result of any case review. In keeping with the intent for an expedited process, the timeframe for the case review doctor to comply with the commission's request for clarification is not changed from proposal.

SUBSECTION (n)

COMMENT: Commenter recommended language be added to ensure that responsibility for case review fees will ultimately be the responsibility of the nonprevailing party at the SOAH level, to include language to address the process and reasonable timeframe for the refund of any case review fees paid at AMDR level. Commenters also recommended deleting the word "final" and include language to ensure changes to the process recommended in (m) are taken into consideration when defining a decision and order.

RESPONSE: The commission disagrees that the liability for the case review fee will be determined at the SOAH level, as liability for the case review fee is determined by the provisions in subsection (n), and the AMDR decision and order is final and not subject to further review. Accordingly, the commission declines to amend the language of subsection (n) to delete the word "final" or to include a right to SOAH review and a process for determining the nonprevailing party at SOAH. However, to establish a reasonable timeframe for the refund of the case review fee, the commission has amended proposed paragraph (n)(5), now (n)(4), to extend the timeframe for all parties to comply with the decision and order from within "5 days of issuance" to "20 days of receipt." The commission disagrees with the recommendation to change subsection (m) and therefore, the request to make the same changes in subsection (n) is moot.

COMMENT: Commenters request that there be an appeal process for AMDR disputes either within the Commission or at SOAH. Commenters further object to the arbitrary nature of the decision process in light of the fact that the AMDR will not be a pure peer-to-peer review, in the IRO process, there is still an opportunity to appeal decisions. This decision process will unfairly penalize the provider on the opinion of one reviewer. Commenters propose a one-time appeal process with IROs for a lesser fee and with the 3-page single-sided documentation requirements for the disputing parties. Commenters challenge the "All Medicare All the Time" principle in that under the Medicare program, providers are not charged for the privilege of appealing an adverse reimbursement decision.

RESPONSE: The commission declines to amend the rule to comply with the commenter's request for an appeal process for AMDR disputes either within the commission or at SOAH. The legislature gave the commission broad discretion to create an "alternative" dispute resolution process to resolve disputes

regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization. The legislature and the commission both recognized the need for a resolution mechanism for low-dollar medical service disputes. The current system leaves providers little economic incentive to challenge denials of payment for services costing less than the cost of an IRO review. These costs were being absorbed by providers or injured workers who paid out-of-pocket. The AMDR process adopted herein was designed to resolve low-dollar medical service disputes for a nominal review fee. In keeping with the commission's charge to control system costs while ensuring the provision of quality health care to injured employees, the commission needed to make the AMDR process as streamlined and efficient as possible. Generating appeal costs either internally at the commission or through proceedings at SOAH is inconsistent with the objective of cost containment. The adopted AMDR process wherein the case review doctor's decision and order is final and not subject to further review is the commission's determination of the appropriate level of due process for small dollar disputes, and is in keeping with the commission's statutory charge to contain system costs. Generating hundreds or thousands of dollars of legal fees to contest a small dollar prescription or service drives overall system costs up. No matter which party prevails at hearing, the system as a whole loses. The adopted rule provides an expeditious process that resolves the threshold problem for low-dollar disputes by reducing the fee to a proportionate $100. Efficiency of process translates to reduced overall system costs. The shortened timelines for the process maintain the efficiency that translates to reduced costs. The opportunity for both requestor and carrier to provide justification for their respective positions on medical necessity is an appropriate measure of due process to afford the parties for the interest at stake. The determination of liability for the AMDR review fee upon decision and order makes the process equitable for all parties. And the finality of the decision and order is an efficient resolution for low-dollar disputes that will keep system costs in line. The commission disagrees with commenters that the process is arbitrary. As stated above, both the requestor and carrier have opportunity to provide input to the decision maker in the dispute, and that decision maker, the case review doctor, is selected by the commission from an appropriate field of medicine having the same or similar licensure as the prescribing or performing doctor. Further, the commission will monitor decisions and request clarification as appropriate. The commission will also monitor case review doctors and their decisions and will take action with respect to case review assignment as appropriate to maintain a list of only those who make well-reasoned decisions. The commission disagrees with the commenter's proposal for a one-time appeal process to an IRO for a reduced fee. This is neither in keeping with efficiency, as this will delay outcomes considerably, nor in keeping with minimizing system costs. The commenter's reference to an appeal without costs to providers in the Medicare system does not address increases in overall system costs through appeal processes. In addition, the Texas Labor Code requires a fee and assesses it against the nonprevailing party.

COMMENT: Commenter stated that subsection (n)(1), where the case review doctor's decision is final appears to contradict and is inconsistent with Texas Labor Code §413.031(k), which provides a party has a right to a hearing by SOAH if dissatisfied with the medical dispute resolution conclusion. Commenter further expressed that to deny any party from substantive and procedural due process rights is unconstitutional. The right to review under the proposed AMDR process is of fundamental importance to the integrity of the system and all its participants.

RESPONSE: The commission disagrees with the commenter's brightline interpretation of the enabling provision found at §413.031(m) of the Act. The legislature gave the commission broad discretion to create an "alternative" dispute resolution process to resolve disputes regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization. The enabling provision at §413.031(m) must be viewed not only in the context of the other provisions of §413.031, but within the context of the entire Act. Further, the enabling provision cannot be interpreted in such a way as to produce an absurd result as all statutory provisions are presumed to have operative meaning. Reading §413.031(k) as being applicable to the AMDR process produces an absurd result and ignores the Act as a whole. The Legislature and the commission both recognized the need for a resolution mechanism for low-dollar medical service disputes. The AMDR process adopted herein was designed to resolve low-dollar medical service disputes for a nominal review fee. In keeping with the commission's charge under the Act to control system costs while ensuring the provision of quality health care to injured employees, the commission needed to make the AMDR process as streamlined and efficient as possible. Generating appeal costs through proceedings at SOAH is inconsistent with the objective of cost containment, and produces an absurd interpretation of the enabling provision, creating process while losing sight of any objective, economic sense. The adopted AMDR process wherein the case review doctor's decision and order is final and not subject to further review is the commission's determination of the appropriate level of due process for small dollar disputes, is in keeping with the commission's statutory charge to contain system costs, and provides operative meaning to the enabling provision. Generating hundreds or thousands of dollars of legal fees to contest a small dollar prescription or service drives overall system costs up. No matter which party prevails at hearing, the system as a whole loses. This interpretation of §413.031(k) and (m) produces absurd results. In addition, the commission notes that subsections (h) and (i) of Labor Code Section 413.031 address who pays for the cost of medical dispute resolution. In particular, subsection (i) states that, except for preauthorization disputes, the cost of the review shall be paid by the nonprevailing party. Subsection (m), which authorizes the commission to prescribe an alternate dispute resolution process to resolve disputes regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization, also states that the cost of a review under the alternate dispute resolution process shall be paid by the nonprevailing party. If the provisions in the remaining subsections of Section 413.031 were meant to apply to subsection (m), the provision in (m) regarding payment of the review fee would be surplusage and meaningless, contrary to the canons of statutory construction. Therefore, the commission adopts the AMDR process with subsection (n)(1) as proposed. As stated above, the adopted AMDR process represents the commission's determination of the appropriate level of due process given the limited property interests at stake, and is also a balance of those due process rights and the obligation of the commission to contain system cost while enabling the delivery of quality health care to injured employees. Again, the ability of the requestor and the carrier to provide documentation to the decision maker in the dispute and

the assignment of liability for the review fee upon determination of the medical necessity issue represent adequate due process for low-dollar disputes. Lastly, with the safeguards in place to protect against undue influence on the case review doctor, and the constant monitoring of the process and the case review doctors by the commission, the commission disagrees that an appeal right is fundamental to system integrity.

COMMENT: Commenter indicated that the rule could result in physicians dramatically cutting down the need for physical therapy/occupational therapy referrals and prescriptions for care. Commenter further indicated that fewer referrals will in the short term "save" money by unfairly penalizing the referral physician. Patients who may benefit from physical therapy may not have the chance to be evaluated due to fewer referrals and due to physicians' fear of financial repercussions. Commenter stated that physicians may be overly hesitant to prescribe necessary procedures, therapies, or testing. It is conceivable that this may ultimately compromise the health and recovery and ability of the injured worker to return to work. Commenters stated that physicians may not even be aware that the prescribed care has been disputed until notified that they must reimburse the insurance carrier the $100 for care determined to be not medically necessary. Commenter stated that it is the role of the physical therapist to evaluate each patient to determine the need for physical therapy as this is what they are specifically trained to do. In addition, commenter states that as a physical therapist and medical professional, he is responsible and accountable for the decision made in regards to whether he believes the patient will benefit from physical therapy and stated, "The physician is in no way responsible for my clinical and professional judgment."

RESPONSE: The commission disagrees that the rule, as now adopted with changes to subsections (i), (j), (k) and (n) eliminating the prescribing/referring doctor's ultimate liability for the case review fee for recommended physical therapy, will curtail referrals for needed medical services if in their professional medical opinion the services are warranted. Further, all health care providers are obligated to provide medically necessary care, as it is unethical by their practice acts not to do so. Injured employees will continue to receive needed care as all health care providers in the workers' compensation system are obligated to assist in reaching the goal of appropriately prompt and healthy return to work. Accordingly, drop-offs in quality of care and delays in return to work are not anticipated by the commission. Based on the above cited changes to the rule as proposed, the commission disagrees that it is possible that a doctor may not be aware of a filed dispute until notified that they are liable for reimbursement of the case review fee. With respect to referrals for physical therapy, the cited rule changes eliminate the prescribing/referring doctor's liability for the case review fee. With respect to prescriptions to a pharmacy or durable medical equipment provider, the rule requires the prescribing/referring doctor to provide the supporting documentation for the requestor's dispute, and provides the prescribing/referring doctor with notice well in advance of any request for reimbursement of a case review fee. The commission recognizes that physical therapists are required by their practice act to evaluate each patient to determine the need for physical therapy. The commission further recognizes that such an evaluation and the recommended treatment course, if any, should be communicated to the referring physician for concurrence. The commission disagrees with commenter's implication that the referring doctor has no accountability for their professional medical opinion that an injured employee requires physical/occupational therapy, pharmaceutical services, etc. To the contrary, it is the commission's expectation that the prescribing/referring doctor is primarily accountable for needed treatment and services, and must remain actively engaged in monitoring the injured workers' progress with the referral HCP as required by the statute and commission rules.

COMMENT: Commenter stated that it is inappropriate and unfair for a physician to be required to pay the fee of a disputing therapist. Commenter believes that it is more appropriate if the specific health care provider who is disputing the denial is responsible for the $100 review fee. This would be consistent with the language of HB-3168, which requires the cost to be paid by the nonprevailing party. A commenter suggested that the requestor should pay the review fee or share the cost of the fee with the prescribing doctor. One commenter recommended that the review fee be deleted from the rule. Another commenter recommended that carriers pay the case review fee as it is their responsibility to pay for an unbiased third party review if the carrier believes services are not medically necessary, or otherwise, and if the third party agrees with the carrier, the claim should be denied without penalty imposed upon the prescribing physician. Commenters also stated that it is unreasonable to ask or expect a referring physician to monitor the daily treatment when treatment is provided outside the referring physician's office. Commenter stated the rule shifts responsibility to the wrong provider and does not encourage responsibility in the HCP who is delivering the treatment.

RESPONSE: The commission agrees that a requestor, other than an injured employee, should be initially liable for the case review fee, and the rule has been changed accordingly from proposal. The prescribing/referring doctor is responsible under the statute and commission rules for ensuring that the prescribed/referred services are medically necessary. In recognition of this responsibility, the prescribing/referring doctor is afforded party status under the rule and may ultimately become the nonprevailing party for prescribing/referring medically unnecessary pharmacy or durable medical equipment service. The commission clarifies that for AMDR purposes, pharmacists and durable medical equipment providers may request review under this rule, but they are not liable for the case review fee in the event that the prescribed/referred treatment or service is determined to be not medically necessary. The prescribing/referring doctor is liable for the case review fee in such circumstances. The pharmacy or durable medical equipment provider, however, will not be reimbursed for provided treatment or services that are determined to be not medically necessary. The commission disagrees that the case review fee should be eliminated. See §413.031(m). This also ignores the economic reality of providing the review. The commission further disagrees with the express recommendation from commenter that the carrier pay the review fee in all circumstances, no matter the outcome. First and foremost, the proposition is contrary to the enabling statute that assigns liability to the nonprevailing party. Secondly, that scenario is not equitable and provides no check on frivolous disputes being filed. Accordingly, in response to public comment, the rule as adopted has been changed to require the requestor (except for injured employee) to initially pay the case review fee. Regarding physicians monitoring referred services, the commission clarifies that it is not the expectation of the adopted rule to force the referring doctor to monitor the daily treatment provided outside the referring doctor's office. However, the referring doctor has accountability for their professional medical opinion that an injured employee requires the referred services as well as responsibility to monitor,

on a regular basis, that the prescribed/referred service is providing measurable improvement or requires modification. Therefore, the commission disagrees that the rule improperly shifts responsibility to the wrong provider as the adopted rule reinforces where accountability resides.

COMMENT: Commenter stated that many physicians might be convinced to exit the workers' compensation system, which will encourage a further reduction in the workers' compensation options for health care. Commenter stated that the commission must continue to represent the workers of Texas and not the private insurance interests in this state. It appears that the intent of all the changes is to drive good doctors and other health care providers away from the system.

RESPONSE: The commission disagrees that this rule will result in a decrease in doctors' participation in the workers' compensation system as the adopted AMDR rule provides doctors with a new opportunity to obtain reimbursement for low-dollar disputes for a nominal case review fee. Recovery of costs previously written off should encourage doctors to remain in the worker's compensation system. Doctors that choose to participate in the workers' compensation system are responsible under the statute for managing an injured employee's medical care and the adopted rule recognizes this. These doctors are responsible for providing all reasonable and necessary medical care that aids recovery and return to work. The commission, as the regulatory agency for workers' compensation in Texas, must consider the interests of all participants in the workers' compensation system. The commission disagrees that the intent of changes made in the workers' compensation system is to drive good doctors and health care providers out of the system. To the contrary, changes made to the system by this rule and others are proffered to improve the quality of health care for injured employees and to make the system equitable for all participants.

COMMENT: Commenter stated that the injured worker will ultimately be the one to suffer the most as the referring physicians stop referring patients for fear of a penalty. This will result in an increased length of time off work, decreased productivity and produce the opposite of the desired effect. Commenter states that the insurance carriers are in almost complete total control of deciding what is medically necessary and that the rule provides an incentive for the insurance carriers to dispute reasonable care provided to the injured workers who need it most and will suffer as a result. Commenter stated this rule would have two negative outcomes regarding patient care: injured employees will be returned to work much more prone to re-injury and more severely and injured workers are much more likely to develop chronic conditions involving the initially injured body part. Each outcome results in greater cost to the insurer.

RESPONSE: The commission disagrees that doctors will curtail referrals for needed medical services if in their professional medical opinion the services are warranted. All health care providers are obligated to provide medically necessary care, as it is unethical by their practice acts not to do so. Injured employees will continue to receive needed care as all health care providers in the workers' compensation system are obligated to assist in reaching the goal of prompt and healthy return to work. Accordingly, the commission disagrees that negative outcomes for injured employees such as drop-offs in quality of care and delays in return to work will arise from adoption of this rule, especially in light of changes from proposal to the adopted rule. Furthermore, the commission disagrees with commenter's characterization that placing liability for the case review fee on the prescribing/referring doctor is a penalty (now only applicable in the case of prescriptions to a pharmacy or durable medical equipment providers). The enabling statute provides that the nonprevailing party is responsible for the case review fee. Procedurally, this is an equitable apportionment of costs between providers with primary responsibility and carriers. If a needed medical service or treatment is required on the injured employee's behalf, a treating or referring doctor should not fear or hesitate in referring the injured employee to an appropriate specialist or specialty for medically necessary treatment. Further, the doctor should not fear substantiating the needed service or treatment in the event of an insurance carrier denial based on lack of medical necessity. Initial insurance carrier denials often occur when medical necessity is not adequately supported or justified, and subsequent substantiations of medical necessity by the referring doctor on behalf of other health care providers is a fundamental process in all health care systems, including workers' compensation. The commission disagrees that such common practices by carriers should be construed as placing carriers in complete control of an injured employee's health care. This rule will help prevent that by providing an economically viable process for review of a carrier's decision. The commission further disagrees with commenter's expectation that AMDR will produce negative outcomes for injured employees, as AMDR is designed to aid injured employees by providing a forum for the recovery of low-dollar out-of-pocket expenses, and additionally providing assistance to injured employees from commission staff in filing their disputes. For all the above reasons, the commission disagrees that injured workers in Texas will be more prone to re-injury and more likely to develop chronic conditions involving the initially injured body part. Referrals for medically necessary physical therapy are expected to continue to benefit injured employees in Texas.

COMMENT: Commenter stated that the physician should not be penalized for the actions of the therapist any more than the therapist should be penalized for the actions of the physician. A physician in an AMDR dispute has no choice as to whether or not an appeal will be filed and is subject to an administrative sanction if he or she does not provide the summarized medical record, the cost of summarizing such records is also born by the physician. Commenter suggested that the requestor pay a preparation fee to the prescribing/referring doctor for the supporting documentation. Commenter stated that the prescribing physician has no knowledge of how the disputed services are reported, billed, documented or charged to the insurance carrier. Commenter further states that there are too many factors that fall outside the scope of the prescribing doctors' care to punitively assign the fee to the prescribing doctor. Medical necessity disputes can be subjective and based on opinion, not substantive research data. Commenter further states that penalizing a physician for honest professional disagreement is not a solution to the high cost of workers' compensation in Texas. Commenter stated that the $100 is an incentive for the reviewing doctor who has never physically evaluated the injured worker (and who is paid by the insurance carrier) to deny medical care.

RESPONSE: In response to public comment, the rule has been changed from proposal to require the requestor, except for the injured employee, to pay for the case review fee. Accordingly, the commission disagrees that, under the adopted rule, a doctor will be penalized for the actions of the therapist. The commission disagrees with commenter's characterization that placing

liability for the case review fee on the prescribing/referring doctor is a penalty (now only applicable in the case of prescriptions to a pharmacy or durable medical equipment providers). The enabling statute provides that the nonprevailing party is responsible for the case review fee. The intent of the adopted rule is to hold the prescribing/referring doctor to their obligation to prescribe/refer only that health care which is medically necessary, and to monitor on a regular basis the progress of the injured employee in response to that care. Ancillary HCPs, such as physical therapists, are expected to adhere to professional standards in providing the care, which is prescribed/referred, but they do not have responsibility for its medical necessity. In the case of pharmacists, other than detecting obvious overutilization of medications, the pharmacist may have no knowledge of the prescription's medical necessity. The commission agrees that the prescribing/referring doctor may have little input into the ancillary HCP's decision to request reimbursement through AMDR. However, the adopted rule at subsection (f)(2)(D) requires the prescribing/referring doctor to provide necessary documentation supporting the medical necessity of the disputed care. Again, this is in recognition of that doctor's role in the injured employee's treatment and that doctor's obvious responsibility for the prescribed/referred care. The commission clarifies that the provision or preparation of documentation supporting medical necessity by the prescribing/referring doctor is required upon request by the ancillary HCP. The commission will enforce this requirement upon notice from the ancillary HCP of the doctor's noncompliance. A doctor's failure to comply may result in administrative action against the doctor. The commission agrees that the provision or preparation of supporting documentation is a cost borne by the prescribing/referring doctor, but the commission considers this nominal cost properly allocated to the party with responsibility for the medical necessity of the care. For this reason, the commission disagrees with commenter's suggestion that the requestor pay a preparation fee to the doctor for the supporting documentation. If an AMDR review is requested, the relationship between the prescribing/referring doctor and the rendering HCP should be one where the exchange of information regarding how the disputed services are reported, billed, documented and/or charged, if necessary to aid the doctor's preparation of supporting documentation, should be easily communicated between the practices. The commission disagrees that too many factors fall outside the scope of the prescribing doctor's care to punitively assign the fee to the prescribing doctor. This comment ignores the role and responsibilities of the prescribing/referring doctor under the statute, and further ignores the central question in the dispute regarding whether the care prescribed/referred by the doctor was medically necessary. The commission disagrees that resolution of medical necessity issues is so subjective as to prohibit the assignment of liability for the case review fee to the prescribing/referring doctor. (This assignment of liability is now only applicable in the case of prescriptions to a pharmacy or durable medical equipment providers, as nonprevailing physical therapists are not reimbursed the case review fee in the rule as adopted.) Professionally recognized standards of care and nationally recognized treatment protocols can be used by the case review doctor to evaluate medical necessity objectively. Further, the requestor has an opportunity to produce documentation explaining the medical necessity of treatments outside these normative standards. The commenter's characterization of AMDR's assignment of liability for case review fees as a nonsolution to the high cost of workers' compensation in Texas is misplaced. The adopted rule is designed, as was the statute, to provide a forum for the resolution of low-dollar disputes based upon medical necessity. However, AMDR is expected to lessen the number of unnecessary referrals and give carriers an opportunity to revisit evaluation practices with respect to low-dollar services, thereby lowering the cost of workers' compensation in Texas. The commission disagrees that the initial case review fee may be an incentive for the reviewing doctor to deny medical care because the payment, based on changes to the rule regarding initial liability of the case review fee, is now generally provided by the requestor. Furthermore, the commission's Medical Quality Review Panel, together with the commission's Medical Advisor, will monitor decisions for any such questionable practices or biases exhibited by case review doctors either siding consistently with a carrier, or siding consistently with a health care provider.

COMMENT: Commenter stated providers will be discouraged from seeking relief on denied claims through the AMDR. It would be a disincentive for physical therapists and others to pursue dispute resolution for fear of causing difficulties for the referring or prescribing doctor and will further hurt the clinician-physician referral relationship. The end result is no different than the current process in that the insurance carriers benefit from the avoidance of the AMDR or IRO processes. Another commenter indicated that the insurance carriers will abuse this situation and will subsequently increase their claim denials, essentially with impunity.

RESPONSE: For reasons previously stated regarding changes to the rule as proposed, the commission disagrees that providers will be discouraged from seeking relief on denied claims through AMDR and that the process will foster disincentives for physical therapists and others to pursue dispute resolution for fear of causing difficulties for the referring or prescribing doctor. The commission further disagrees that AMDR will further hurt the clinician-physician referral relationship. Additionally, the commission disagrees that insurance carriers stand to benefit from this AMDR process because carriers are ultimately liable for the case review fee in an AMDR dispute when the insurance carrier does not prevail and in all cases when the requestor is an injured employee. In addition, this rule will result in the filing and resolution of more medical necessity disputes, which is not necessarily advantageous to the insurance carrier. The commission also disagrees that carriers benefit from existing IRO medical dispute processes because in the IRO process carriers are often required to reimburse the IRO fee to the prevailing party. The commission does not foresee carriers' abuse of the system, but if such abuse arises, it will result in appropriate administrative penalties by the commission's Compliance and Practices Division. The commission disagrees that AMDR provides incentives for carriers to increase claim denials with impunity. To the contrary, low-dollar disputes that were formerly not economical to contest will now be held up to scrutiny.

COMMENT: Commenters recommended the removal of language in subsection (n)(2) that requires the prescribing doctor to pay for the case review fee. Commenters stated that this requirement promotes a punitive assignment of a fine on referral sources when they do not have direct control over which CPT codes and exact procedures are rendered by the servicing provider. Commenter stated that the rule as written could result in literally thousands of dollars in case review fees for the prescribing doctor. Commenter recommended that proposed rule not be adopted in its current form because adoption without change will allow carriers to continue their abuse of the rehabilitation providers and this will have a negative outcome and disastrous consequences for the individual in need of rehabilitation and the rule will not achieve the result of providing patients

with an acceptable level of fair and necessary rehabilitation services. Commenters further recommended the commission consider looking for more proactive solutions of the adjustor, physician/healthcare provider, patient, and employer working together to get the patient back to work with equitable payment being given for services provided. Commenter recommended that language be included to prevent pharmacists from filing disputes every time because there are literally dozens of reasons why the carrier disputes pharmaceuticals (e.g., pharmacists fills brand name instead of generic). The commenter included recommended language to inform the prescribing doctor each time a pharmacist files a dispute, give the prescribing doctor an opportunity to provide supporting documentation, and to remove liability from the prescribing doctor for the case review fee where pharmacists filed prescriptions erroneously or with knowledge that the carrier disputed the prescription. Commenter stated that pharmacists feel that requiring the requestor to pay is an issue that can be worked out with the prescribing doctor in their community. Commenter further stated that the commission should review potential problems with assignment of liability for the case review fee when multiple billings are combined by pharmacists that feature multiple prescribing doctors. Commenter recommended that the mechanisms need to be expanded to allow for the suspension of health care providers from participation in workers' compensation program when the health care provider has a majority of adverse determinations (greater than 66% of a threshold level of 20 IROs); and, if a carrier has a majority of adverse determinations greater than 66%, the carrier should be substantially, monetarily fined for abuse of the system. Commenter recommended the $100 should be paid by the carrier if the carrier loses and come from the SIF if the carrier wins. Commenter recommended the commission reconsider the wording of the new rule.

RESPONSE: The commission disagrees in part with the suggested removal of language in paragraph (n)(2) of the proposed rule that required the prescribing doctor to reimburse the case review fee. However, in response to public comment, the commission has changed paragraph (n)(2) from proposal to only require the prescribing/referring doctor to reimburse the nonprevailing requestor when the requestor is a pharmacy or durable medical equipment provider. No other parties shall reimburse, or be entitled to reimbursement of, the case review fee where none of the disputed care was determined to be medically necessary. The commission disagrees that a prescribing/referring doctor stands to lose thousands of dollars in case review fees especially in light of the adopted changes to (n)(2). The rule as adopted provides a disincentive to doctors who habitually prescribe unnecessary pharmacy or durable medical equipment services. The commission disagrees with commenters' assertion that the rule as proposed allowed carriers to continue their abuse of rehabilitation providers. The adopted rule provides a forum for health care providers' recovery of denied billings associated with low-dollar services previously absorbed by providers. For reasons previously stated regarding the continued delivery of medically necessary referrals for physical therapy, the commission disagrees that AMDR will produce negative and disastrous effects on access to rehabilitation services. This is particularly true in light of changes to the rule as proposed eliminating a prescribing/referring doctor's ultimate liability for the case review fee when physical therapy services are determined to be not medically necessary. The commission agrees that seeking more proactive solutions between adjustors, doctors, other health care providers, injured employees, and employers working together to get the patient back to work with equitable payment being given for appropriate and medically necessary services provided is a desirable goal for all system participants. The adopted rule addresses equitable reimbursement for medically necessary health care, which, indirectly, should affect the number of unnecessary referrals and return injured employees to work sooner, when appropriate. The commission disagrees that pharmacists should be prevented from filing disputes as they are equally entitled to reimbursement for care that is medically necessary for an injured employee's condition. Further, the commission clarifies that if a carrier has more than one reason for denying pharmaceutical services, those reasons should be declared in their EOB denial of a medical bill. Consequently, the pharmacy may learn why the care was denied, and have an opportunity to file a request for AMDR or other appropriate medical dispute resolution after the pharmacy has requested reconsideration from the carrier based on all reasons for denial. The commission disagrees that the recommended language requiring the pharmacist to notify the prescribing doctor of the AMDR dispute is necessary as the pharmacist must go to the prescribing doctor for documentation supporting the medical necessity of the prescription to file their dispute. The commission disagrees that aggregation of multiple billings by pharmacists will lead to the unintended consequence of combing billings from multiple prescribing doctors with the resultant confusion regarding liability for the case review fee. Subsection (b)(1) requires single or multiple billings to be claim-specific (pertaining to a single claimant). The commission further clarifies that in the rare circumstance that disputed prescriptions for a single, injured employee come from multiple providers, whether claimed on a single bill or multiple billings, the pharmacy must dispute these separately. The commission disagrees that AMDR is the appropriate forum for recommendations concerning the suspension of health care providers from the workers' compensation system, or assessment of heavy fines on insurance carriers, when they have experienced a majority of adverse determinations. Appropriate mechanisms for such reviews already lie within the commission's Medical Review Division and Compliance and Practices Division. The commission also disagrees that a more appropriate arrangement for the payment of the case review fee and wording of the rule is one where the fee would be paid by the carrier if the carrier loses, and be paid from the Subsequent Injury Fund (SIF) if the carrier wins. As stated above, such an arrangement is contrary to the enabling statute that requires the nonprevailing party to pay the case review fee, and statutory provisions regarding reimbursement from the SIF. The commission has determined the assignment of liability for the case review fee is appropriate as adopted.

COMMENT: Commenter stated the implied root of over-prescription is self-referral. The most obvious way to reduce this problem is to eliminate self-referral of patient's to facilities that have Physician or Chiropractic ownership. This would then restore integrity to the system. The physicians would once again be considered the standard for determining the medical needs of their patients. Commenter stated that the rule proposal will result in physicians reducing the number of referrals, however, due to the relatively low-cost of reimbursement to the insurance carrier, this rule will not affect the Physicians/Chiropractors who refer their patient within their own clinics. Another commenter asked what fine is going to be available for all the chiropractors that refer every patient to themselves. Commenter continued that AMDR appears to be another way to deter legitimate referrals, and that commenter strongly opposed any legislation that randomly punishes legitimate practitioners. Another commenter stated that it appears the intent of this rule is to discourage doctors from self-referring for monetary gain, which is encouraging. This, however,

would have an adverse effect on ethical, legitimate providers who depend on referrals from outside sources. Another commenter indicated that this rule and the effects of this change in the dispute process could readily create the opportunity for more physician-owned clinics, reduce referrals to independent non-physician practitioners, and ultimately reduce necessary treatment in the Return-to-Work process. Another commenter assumed that the goal of the rule language is to reduce fraud from physicians referring patient's who would not benefit from skilled therapy, to therapy facilities with whom they have a financial relationship.

RESPONSE: The commission disagrees that the intent or purpose of the AMDR rule is to address self-referrals of a doctor who may have ownership in a facility, clinic or practice. Commenters' concerns regarding fraud, abuse and fines for self-referrals, and other issues related to financial disclosure are outside the scope of this adopted rule. Commission Rule 180.24, regarding Financial Disclosure, addresses these requirements in compliance with the statute, which requires financial disclosure but does not prohibit self-referrals.

COMMENT: Commenter stated that physicians may opt not to try therapy and may opt to treat with steroids to relieve pain and inflammation symptoms or surgery that may result in much more physical and financial burden. Commenter stated physicians who may file workers compensation might be more financially able to take the liability since their usual and customary charges for each and every patient may be more to compensate for possible $100 fees. Rises in healthcare costs are major problems that may increase if this rule is passed. Another commenter stated AMDR will result in doctors not referring patients for physical/occupational therapy and then the federal government will foot the bill with social security disability payments. Consequently, many insurance carriers will be collecting premiums, not paying legitimate claims, and not taking responsibility for their insured. Commenter stated that the rule presupposes that there is a deliberate tendency by referring doctors to over-prescribe rehabilitation services. Commenter further stated that the rule does not define "reasonable and necessary," and that there is too much subjectivity in these terms and this exposes the considered determinations of referring provider to the whims, predispositions and opinions of another provider. A commenter implored that the proposed rule be dissolved while another commenter requested that the language be modified to prevent codifying a rule that will potentially cause more problems than it resolves.

RESPONSE: The commission disagrees that a doctor will attempt different forms of therapy or treatment to avoid referrals to a specialist or specialty because doctors are obligated under §408.021 of the Act to provide all health care reasonably required by the nature of the injury as and when needed. The commission disagrees that the adopted rule will result in an increase in health care costs associated with doctors' usual and customary charges because if doctors are making legitimate referrals based on medical necessity, the nominal case review fee is borne by the insurance carrier. The commission disagrees that AMDR provides an incentive to carriers to fail to pay legitimate claims. On the contrary, as more low-dollar fees are disputed, carriers are expected to review their retrospective review processes to avoid the cost of unnecessary AMDR requests. As previously stated, the commission clarifies that the intent of the adopted AMDR rule and process is to implement an expedited alternate process for low-dollar disputes regarding medical necessity for a nominal fee. It is not the intent of the rule to address referral patterns. Further, the adopted rule does not presuppose that doctors over-prescribe rehabilitation services. However, the commission expects that unnecessary referrals will decrease post-adoption. Since the term "reasonable and necessary" is widely used throughout the Act and commission rules, the commission disagrees that a specific definition should be developed for inclusion in this rule.

COMMENT: Commenter stated the rule proposal will compromise the therapist/physician relationship and ultimately limit patient care. Commenter continued that it is likely that an additional consequence of the rule will be to undermine and adversely impact the relationships between doctors and therapists or pharmacists and the referral structures that are currently in place. Commenter expects doctors will be less likely to use therapy, resulting in delayed recovery for many more injured employees and the necessary referral mechanisms that have developed over time will deteriorate. Commenter stated that the rule proposal has the potential of creating an environment of fear, intimidation which lead to very poor care of the injured employees and the rule will place an unnecessary hardship on clinics and pain physicians who refer pain patients for physical therapy evaluations.

RESPONSE: The commission disagrees that the adopted rule compromises or has an adverse impact on the therapist/doctor relationship. Health care providers are obligated to provide medically necessary care, as it is unethical by their practice acts not to do so. Further, the Act provides that injured employees are entitled to all health care reasonably required by the nature of the injury as and when needed. Injured employees will continue to receive needed care as all health care providers in the workers' compensation system are obligated to assist in reaching the goal of appropriately prompt and healthy return to work. Consequently, the commission disagrees that patient care will be limited and recoveries will be delayed by this adoption. The commission further disagrees that necessary referral mechanisms that have developed over time will deteriorate. An appropriate relationship between the doctor and whom they refer their patients to should encompass regular communications as to the scope and progress of recommended treatments for the injured employee. The adopted rule requires coordination between professionals in the event of a denial of payment by the carrier. Injured employees are expected to benefit from this greater coordination and exchange of information. Consequently, the commission disagrees that the adopted rule will create an environment of fear and intimidation and negatively impact the quality of care provided to injured employees. Similarly, the commission disagrees that the adopted rule will place an unnecessary hardship on clinics and pain physicians. However, in response to public comment, the commission has changed the rule to require a requestor (including physical therapists) to initially pay the case review fee, but in the event the requestor does not prevail, unlike in the case of pharmacies or durable medical equipment providers, the prescribing/referring doctor will not reimburse the case review fee to a physical therapist. This change in the rule was made to address the concerns of physical therapists regarding their perceived loss of outside referrals from prescribing/referring doctors arising from the doctor's liability for the case review fee in the rule as proposed.

COMMENT: Commenter stated the rule allows questions regarding decisions to refer patients for rehabilitation services and puts physical and occupational therapists at a significant business disadvantage. Commenter opined that due to the nature of the rehabilitation system and the documented importance of quick

intervention, these specialists typically complete their work on most of their patients before the insuring company even contemplates advancing a dispute. Commenter indicated that the rule does not account for payments for the legitimate work of these rehabilitation specialists as is provided on the basis of a referral from a care provider, whom the state has licensed to make such referrals. The proposed rule is an attempt to control utilization by "fining" the referring physician, and will be detrimental to HCPs who can only have access to injured employee's through referrals (by law).

RESPONSE: The commission disagrees that the AMDR rule places rehabilitation service providers at a significant business disadvantage. Carriers are required to retrospectively review all complete medical bills and pay for or deny payment for medical benefits pursuant to §133.301(a) of this title. Physical and occupational therapists are in no different position than other system providers who deliver care that does not require preauthorization for health care that is prescribed or referred to them by another HCP. The adopted rule does not alter this system paradigm, but provides an expedient review of low-dollar disputed care. Furthermore, it opens avenues to reimbursement for denied care that previously had to be written off for economic reasons (the relatively high IRO review fee). The commission further disagrees that the rule does not account for payments for legitimate work performed by rehabilitation specialists as is provided on the basis of a referral from a care provider. Those legitimate services that were not contested will have been reimbursed by an insurance carrier and would not require the need for an AMDR case review. Those legitimate, low-dollar services that were denied payment by the carrier as medically unnecessary now have an expeditious review process by virtue of the adopted rule. The commission disagrees that the rule as proposed was an attempt to control utilization by "fining" the referring doctor; however, with changes to the rule as adopted, which eliminate a prescribing/referring doctor's ultimate liability for the case review fee when physical therapy services are determined to not be medically necessary, is no longer an issue with respect to physical therapy.

COMMENT: Commenter stated the rule does not address the punishment of the insurers for unnecessarily and improperly denying payments.

RESPONSE: The comment addresses issues outside the scope of the adopted rule. Carriers, like other system providers, are subject to review for their practices by both the divisions of Medical Review and Compliance and Practices. Other provisions in the Act and rules address patterns of improper denials of payments by carriers and appropriate sanctions therefore.

COMMENT: Commenter recommended amendments to subsection (n)(3) as proposed, deleting the term "the" and replacing with "a final" and to delete the term "any" and replace with "the majority." Commenter indicated these recommended changes would ensure clarity for determining liability for the case review fee. Commenter recommended that the "majority" of disputed care will determine the prevailing party as opposed to "any" of the care.

RESPONSE: The commission disagrees with recommended language substitutions to subsection (n)(3) because subsection (n)(1) clearly states that an AMDR decision is final and not subject to further review. The commission disagrees with the additional recommended language that places the case reviewer in a position to decide which party prevails in the "majority" of services in dispute because the majority of disputed care is not a factor in determining the prevailing party under this section. In keeping with the intent of creating an expedited process for a nominal case review fee, the commission has determined the word "any" is the appropriate language for this rule.

COMMENT: Commenter recommended a new subsection (n)(4) that allows for an AMDR dispute to proceed to a contested case hearing at the SOAH, which would ultimately decide whether the disputed care was medically necessary, and consequently, liability of the case review fee. Due to the recommendation of a new subsection (n)(4), commenter additionally recommended re-numbering the remaining subsection of (n).

RESPONSE: The commission disagrees with a recommended subsection allowing for the appeal of an AMDR decision because the intent of this exclusive, low-dollar alternate dispute resolution process is to create an expedited process for a nominal fee. Parties who file a request for AMDR are expected to understand that the decision and order is final and not subject to appeal. Detailed reasoning in prior comments addresses the commission's reasoned justification regarding the finality of the decision and order.

COMMENT: Commenters recommended that the timeframe for a party to comply with the decision and order in subsection (n)(5) of the rule as proposed is unrealistic and does not provide adequate time to issue a check. One commenter recommended seven days to issue a check and another recommended 10 days. Another commenter agreed with the five-day reimbursement requirement. Commenter recommended deleting "issuance" and replace with "receipt. A party should only be responsible for providing a response after a confirmed receipt of a final decision. Other rules related to dispute resolution make similar provisions for addressing timeframes in relation to the RECEIPT of various documents and notifications.

RESPONSE: The commission considered the five day proposed timeframe and has agreed to change the language in proposed (n)(5), now (n)(4), to read, "a party shall comply with a decision and order within 20 days ...." The commission agrees that parties require an adequate amount of time for the issuance of a check after the decision and order is issued. To be consistent with other commission mailing requirements, the commission also agrees with the recommendation to change the proposed text from "issuance" to "receipt," and has changed the rule accordingly upon adoption.

COMMENT: Commenter was concerned that subsection (n) would require carriers to have to respond to the same disputed issue over and over again. Such a policy restricts the ability of the carrier to look out for the interests of the injured employee, and carriers should not have to fight the same battle over and over again. Another commenter recommended amending subsection (n)(6), deleting "this" and replacing with "a final," and adding language that a requesting party may not use the final decision and order to support future medical care because it ensures that a dispute of limited scope is not taken out of context and utilized to impact the outcome of large-scale treatment issues.

RESPONSE: The commission disagrees that an insurance carrier will have to repeatedly respond to the same disputed issue because the commission will utilize screening criteria for excluding previously adjudicated disputes for the same dates of service involving the same parties. Additionally, the commission recognizes that carriers should also utilize screening mechanisms to ensure that the same disputed issues are not repetitively reviewed. The commission also disagrees with the recommended

language substitution in what is now (n)(5), because it is the insurance carrier that has the ability to deny reimbursement on future medical care and not the requesting party who must justify and support the medical necessity of future health care. In addition, decisions issued in the AMDR process will be low-dollar disputes with a limited scope of review, which would be difficult to use to impact the outcome of large-scale treatment issues that may come under review in §133.308, regarding Medical Dispute Resolution by an Independent Review Organization, or §133.307, regarding Medical Dispute Resolution of a Medical Fee Dispute.

SUBSECTION (o)

COMMENT: Commenter recommended the commission develop written criteria for AMDR to be dismissed, and indicated the proposed language was subjective and would not prevent filings, which lack substance. Commenter further indicated this will increase commission costs of reviewing submitted cases which may be without merit.

RESPONSE: The commission disagrees with the need to list criteria for dismissing an AMDR dispute. The commission does not anticipate an ongoing need to dismiss case reviews but needs the flexibility to dismiss a review on an "as needed" basis to address unforeseen circumstances, which is why the adopted rule does not contain a list of criteria for dismissing a case review. The commission also disagrees that filing requests that lack substance will increase commission dismissal costs because if a request for AMDR does not qualify for a review it will not proceed in the process and consequently there would be no need to issue the dismissal.

GENERAL COMMENTS

COMMENT: Commenters stated general support for a conceptual alternative medical dispute resolution process that is faster and less expensive than current processes; however, commenters also expressed concerns detailed in other comments of this preamble. Commenters supported a more cost effective dispute resolution process for appealing the denial of reimbursement due to medical necessity on smaller dollar claims. Commenter stated many claims are not going through the current IRO process because of the cost/benefit issues. Commenters stated the current system is completely cost prohibitive for pharmacies and the proposed changes will be of great assistance in helping pharmacists and therapists collect the reimbursements they deserve. Commenters stated the basic concept of a more streamlined AMDR has some merit. Commenter supports the commission's "in-house" process rather than the IRO process as the current medical dispute resolution process is long and tedious and small HCPs do not have the resources to not only lose the time and expense of providing the services, but, then to allocate another $600. Commenter stated IROs are costly and IRO decisions can be overturned by SOAH, which is a very expensive process to go through for the HCP. The commenter stated the rule overall is very, very good and will accomplish it's purpose. Commenter supports the AMDR process with the nonprevailing party absorbing the cost of case review.

RESPONSE: The commission agrees that there is a need for a process such as AMDR that is a faster and less expensive medical dispute resolution process. Responses to commenters' concerns are specifically addressed in other portions of this preamble.

COMMENT: Commenter recommended to not pass a rule that will take practitioners out of the loop or make their job any more difficult than it already is. Commenters recommended that the commission adopt the Medicare program process for adjudicating appeals of denied reimbursement, though this is to too broad a recommendation for considering at this time. Commenter encourages the commission to give more consideration to recommendations made by the Medical Advisory Committee (MAC) as members of the MAC expressed concerns and raised objections to this proposed rule.

RESPONSE: The commission agrees that it should not pass a rule that will take a health care practitioner out of the loop and it is not the intent of this adopted rule to do so. In fact, the adopted rule clearly requires that a HCP remain in the loop of treatment decisions, as required by statute and other commission rules. The commission disagrees with the recommendation to adopt Medicare's appeal process because the workers' compensation appeal process is specific to this system and the enabling legislation for this rule authorizes the commission to create an alternate dispute resolution process to resolve disputes regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an IRO. The commission clarifies that comments and concerns posed by members of the MAC are taken into consideration.

COMMENT: Commenter recommended language be added that explains that the AMDR process (as well as the entire MDR process) is not intended to be used to retrospectively review for medical necessity services that were previously preauthorized or voluntarily certified.

RESPONSE: The commission disagrees that additional language is needed to explain that services previously preauthorized or voluntarily certified are not subject to AMDR. Subsection (b)(3) clearly states that the AMDR process is expressly limited to resolution of retrospective medical necessity disputes. The commission clarifies that a disputing party can and should provide documentation in the request for AMDR that indicates preauthorization or voluntary certification was previously approved from a carrier. This will assist the commission in determining what services were preauthorized and what services were not, thereby avoiding a case review of any preauthorized services. In addition, if the supporting preauthorization/voluntary certification indicates all of the services in dispute were preauthorized, the request will not proceed to the case reviewer, and the carrier will be ordered to reimburse the preauthorized/voluntary certification services and will also be referred to the commission's Compliance and Practices Division for violation of §133.301(a).

COMMENT: Commenter questioned why the commission is implementing a rule that would further limit the number of physicians who will see worker compensation patients rather than implement a rule that cracks down on facilities who overutilize services. Commenter stated that if the Prospective Review of Medical Care is implemented, there will be little need for this AMDR process eventually.

RESPONSE: The commission clarifies that this rule should not limit the number of physicians who will participate in the workers' compensation system. Physicians that choose to participate in the workers' compensation system are responsible for managing an injured employee's medical care and the adopted rule recognizes this. Therefore, the responsibility and accountability of the physicians referring treatment to facilities should impact the overutilization of services. The commission

disagrees in part that proposed §134.650 of this title, regarding the Prospective Review of Medical Care Not Requiring Preauthorization (PRM), will eventually diminish the need for the AMDR process. Proposed rule 134.650 is a voluntary process on the part of both the provider and the carrier. The outcome of the PRM process cannot be retrospectively overturned on medical necessity grounds; and therefore, AMDR would not be necessary. However, because the PRM process is voluntary, many disputes will still arise retrospectively with some portion eligible for AMDR review. Therefore, the need for this rule exists.

COMMENT: Commenters opposed the proposed rule. Commenter stated that this is the wrong approach to the overutilization of services which is driving up the costs of medical care and that the commission already knows who the abusers are but is failing to attack the problem by not auditing and penalizing those providers who, many times, are the referring physicians/chiropractors who own their own rehabilitation clinics. Commenter stated that the rule favors chiropractors, who as treating doctors, are most likely the biggest abusers of the workers' compensation system. Commenter stated penalizing conscientious and honest practitioners along with those guilty of overutilization will not work and that those guilty of overutilization will not file a dispute. Commenter stated those providers who are found to be habitually overusing and those carriers who are found to be habitually refusing to compensate for legitimate treatment/care, are the only entities that should be penalized.

RESPONSE: The commission clarifies that the intent and design of the AMDR rule is for the retrospective review of low-dollar disputes denied for medical necessity, which may include disputes based on overutilization. The AMDR process, and medical dispute resolution in general, is primarily charged with resolving disputes regarding unpaid medical services and not to specifically address assessing penalties to participants in the system. The commission, through the office of the Medical Advisor, is addressing overutilization of health care services in other ongoing initiatives. The commission's Compliance and Practices Division is addressing carrier and provider compliance within the system and is charged with the appropriate assessment of penalties. Because overutilization is often the basis for retrospective denial of medical necessity, this rule should be effective with regard to stopping overutilization.

COMMENT: Commenter stated that another "system" as proposed is not needed.

RESPONSE: The commission disagrees the process established by the adopted AMDR rule is not needed. The need for this process was recognized by the Texas Legislature in its 78th session by enacting House Bill 3168 allowing for an alternate medical dispute process to resolve disputes regarding medical services costing less than the cost of a review by an IRO. During the two-year period of January 2002 through December 2003, approximately 1,100 of the 5,900 retrospective medical dispute filings involved disputes of care with charges totaling less than the tier one IRO fee. Approximately 60% of these disputes were withdrawn or dismissed and were not resolved through the current process, due in part to the IRO fee.

COMMENT: Commenter stated that the utilization of financial disincentives, as promoted by the rule, fall well outside the scope of ethical clinical and business practices and that the rule violates the very principles of the commission which are stated clearly in its mission statement.

RESPONSE: The commission disagrees that the adopted rule provides financial disincentives that fall outside the scope of ethical clinical and business practices, and that the rule violates the very principles of the commission's mission statement. As reasoned in many responses to comments above, the adopted rule complies with its enabling statute, does not permit prescribing/referring doctors to neglect to provide all care that is reasonably required by the nature of the injury as and when needed. The rule provides a low-cost route to the recovery of low-dollar payments denied by the carrier where rendered treatments are found to be medically necessary. The procedural efficiencies of the adopted rule are exactly in keeping with the commission's mission statement. The mission of this agency is to encourage and assist in the provision of safe workplaces; to provide an effective and efficient regulatory framework to facilitate timely, appropriate, and cost-effective delivery of benefits; and to assist in timely returning injured employees to productive roles in the Texas workforce.

COMMENT: Commenter stated that carriers want to make it more difficult or impossible for health care providers to appeal denials and that too much power has been given to the carriers and taken away from the treating physicians. Commenter further states that physical therapists are obviously in opposition to this rule and the Texas workers' compensation system is in need of an overhaul.

RESPONSE: The commission clarifies that the intent of the adopted AMDR rule is to provide a review process that previously did not exist for low-dollar health care denied for medical necessity at a nominal fee. The commission disagrees that too much power has been given to the insurance carriers and taken away from the treating doctors. In fact, this rule provides a mechanism for HCPs to resolve denials of low-cost items, which was not previously available for HCPs. In addition, this process holds the insurance carriers liable for the case review fee if the health care provider prevails in an AMDR dispute. The commission takes notice that many physical therapists were opposed to this rule as proposed. In response to public comment, the commission has changed the rule to require a requestor (including physical therapists) to initially pay the case review fee, but in the event the requestor does not prevail, unlike in the case of pharmacies or durable medical equipment providers, the prescribing/referring doctor will not reimburse the case review fee to a physical therapist. This change in the rule was made to address the concerns of physical therapists regarding their perceived loss of outside referrals from prescribing/referring doctors arising from the doctor's liability for the case review fee in the rule as proposed.

COMMENT: Commenter stated that in the present environment, we hear of cases where "expert" witnesses have a very slanted vision and opinion resulting in very immoral and wrong judgments in contested cases and that practice guidelines are just opinions of some physicians based on some studies that do not apply to every case; each case cannot be judged on a solidly laid down protocol. Commenter stated that medical dispute resolutions, in his/her experience, do not work as they routinely go to the side of the carrier for subjective reasons and no objective information is given for the denial of payment.

RESPONSE: The commission disagrees in part. The commission does not intend to utilize "expert" witnesses with slanted visions that result in immoral opinions or wrong judgments as

AMDR case review doctors. As previously stated, the commission will use doctors from the commission's ADL and such doctors will assess the merits of each case and make a determination of medical necessity based on their education, knowledge, training, experience and research, along with guidance from the Act and commission rules and documentation supplied by the parties. The commission disagrees that the medical dispute resolution process does not work and that disputes are routinely decided in favor of the carrier. The commission's December 31, 2003 System Data Report captures outcomes in the medical dispute resolution process. The overall medical dispute resolution outcomes for health care providers and carriers in 2003 are almost equally split, 49% and 51% respectively. Additionally, the outcomes captured for medical necessity disputes in 2003 were 61% in favor of health care providers. The adopted rule requires the case review report to include specific reasons for the determination, including the clinical basis and screening criteria that were utilized.

COMMENT: Commenters opposed the proposed rule because it will add yet another layer of dispute resolution to an already over burdened system that does not work which will result in more medical disputes, system inefficiencies, less credibility, and unnecessary medical treatment, prompting the system to continue to fail. Commenter stated that the proposed rule is not the answer to the commission's medical crisis and that health care providers and carriers will have no incentive to settle disputes with the carrier prior to filing an application for the AMDR process. Commenter stated that the proposed rule would not provide a balanced medical dispute resolution process. Commenter recommended a system that requires objective information from both the carrier and the provider to prove their stance on a case as a better method.

RESPONSE: The commission disagrees. HB-2600 passed during the 77th Legislative Session mandated the use of IROs for retrospective medical necessity disputes but it was not cost effective to request IRO review for low-dollar disputes. Therefore, the Legislature during the 78th Legislative Session passed HB-3168, which allows the commission to develop by rule an alternate medical dispute resolution process for retrospective medical necessity disputes costing less than the cost of an IRO review. The commission disagrees that the current medical dispute resolution does not work. The process offers system participants an opportunity to seek relief for unpaid health care through the commission with an opportunity to appeal a decision issued by the commission to a higher dispute level. Although the system may be cumbersome and lengthy, it does afford the parties due process. The AMDR process will be more efficient. The commission disagrees that there will be no incentive to settle disputes prior to filing AMDR because the commission has always encouraged disputing parties to obtain an informal resolution to disputes prior to filing a dispute. In addition, the reconsideration process is another opportunity to resolve disputes prior to seeking medical dispute resolution. The commission reiterates that the nonprevailing party is ultimately responsible for the case review fee, which does provide an incentive to resolving a dispute prior to filing an AMDR request. The commission disagrees that the adopted rule will not provide a balanced medical dispute resolution process because parties will be afforded the opportunity to provide an equal amount of supporting medical documentation to prove their position.

COMMENT: Commenter stated a carrier should not be able to dispute treatments at random and bog down providers to such a degree that the provider gives up on a legitimate injury case.

RESPONSE: The commission agrees and the commission rules state that a carrier is liable for all services that are medically necessary for a compensable injury. Carriers are prohibited from randomly denying health care services without reasonable justification. The commission clarifies that a health care provider should not cease providing necessary care to a legitimate workers' compensation injury claim and that a provider should pursue medical dispute resolution for disputed treatments. It is a violation for an insurance carrier to unreasonably dispute the reasonableness and necessity of health care, and the commission will monitor for such activity.

COMMENT: Commenter stated that Texas Mutual Insurance Company recently gave the commission over a million dollars for some reason. Commenter questioned if this was true, what was it for, and how much.

RESPONSE: The comment made by this commenter is not related to, or within the scope of, the AMDR rule and process which is the subject of this rule-making public comment/response process. The commission notes, however, that the Legislature statutorily provided for the grant and the commission met all requirements imposed by the Legislature.

COMMENT: Commenter strongly supports comments made by the Texas Medical Association.

RESPONSE: The commission notes that the commenter strongly supports the comments made by the Texas Medical Association.

COMMENT: Commenter does not support the adoption of the proposed rule, as it will undermine the IRO process by encouraging health care providers to break their disputes up into multiple smaller dollar disputes.

RESPONSE: The commission disagrees that the adopted AMDR rule will undermine the IRO process by breaking up disputes into smaller dollar disputes. The adopted rule and AMDR process will provide for a medical dispute resolution process that previously did not exist. Low-dollar medical disputes costing less than a review conducted by an IRO were not cost effective or feasible for a health care provider to pursue under the IRO process. Health care providers were reluctant to request review by an IRO because of the higher IRO fee and would often write off medical bills and not pursue resolution through the IRO process. The commission clarifies that this rule in no way dictates to health care providers how to bill for their services. Unbundling, as a fee dispute or an enforcement issue, is addressed by other commission rules and processes. Health care services that must be bundled for billing purposes must likewise be bundled for purposes of AMDR requests. Services that exceed the current tier one threshold of $650 will be reviewed by an IRO under §133.308 of this title, regarding Medical Dispute Resolution by an Independent Review Organizations.

COMMENT: Commenter stated the IRO review process is analogous to the AMDR process. Commenter stated the commission could expect a geometric multiplication in expense for and maintenance of the two additional doctor lists due to the AMDR and Prospective Review of Medical Care Not Requiring Preauthorization rules, as the commission intends to track the performance of the reviewers on these new rosters. Commenter further stated that the fiscal impact to the commission will also increase due to the documentation requirements and the commission's need to support this activity of ministering to the parties, the greater burden of assisting the injured employee in compiling the AMDR request, and because the identity of the reviewer

is known to the parties; all leading to more staff. Commenter stated that in their experience in handling, acquiring, condensing, and making available medical records for review would impose a significant fiscal impact on the commission. Commenter recommends the commission release and evaluate its statistics as to the class(es) of review requests that fall into the proposed AMDR category as a rigorous cost-benefit analysis is in order to ascertain that the cost of the administration will not exceed the aggregate of default payments of these claims.

RESPONSE: The commission agrees that the IRO process and the AMDR process are similar. The AMDR process applies to low-dollar medical disputes costing less than a review conducted by an IRO and will be conducted by a commission-selected doctor from the commission's ADL. The commission disagrees that the AMDR process will result in a significant fiscal impact to the commission due to the maintenance of two additional doctor lists, the need to support activity related to the documentation requirements, assisting the injured employees in compiling an AMDR request or due to the identity of the case review doctor being known. There will be minimal costs for utilizing doctors already on the commission's ADL. The commission, through the office of the Medical Advisor, currently tracks performance of doctors on the ADL and will now track the performance of AMDR case review doctors with currently established processes. Also the commission will only need to forward the request to the case reviewer and to the respondent. The respondent will submit their five single-sided page response directly to the case reviewer without commission intervention, minimizing administrative costs. The commission does not foresee a need for additional staff, as current field office staff will provide the necessary assistance to an injured employee filing an AMDR request. The commission clarifies that the commenter did not specify how the known identity of the case review doctor would result in increased costs to the commission. The commenter's experience with the handling of medical records for review is based on unlimited and unspecified documentation requirements for parties requesting and responding to reviews by IROs. The AMDR process specifically limits the number of documents that are required and the commission bypasses the handling of the required documents. At this time in the rule-making process, the commission is unable to conduct a rigorous cost benefit analysis because the commission is not able to determine the actual number of requests for AMDR. As stated in the proposal preamble, during the two-year period from January 2002 through December 2003, approximately 1,100 of the 5,900 retrospective medical dispute resolution filings involved disputes with charges totaling less than the tier one IRO fee. Approximately 60% of these disputes were withdrawn or dismissed and were not resolved through the IRO process, due in part to the IRO fee. Furthermore, the commission cannot issue a comprehensive detailed study at this point in time because the 1,100 disputes is not representative of the potential disputes that could be processed through AMDR as many low-dollar disputes were never filed with the commission.

COMMENT: Commenter recommended the commission consider proposing a pharmacy treatment guideline and the feedback from prescribing doctors, pharmacists and carriers can help determine whether this approach would be more efficient than the proposed AMDR rule. Commenter stated that if this rule proposal is principally to address pharmacy situations, it is addressing only a small minority of the actual need as their IRO experienced approximately 360 MDR/IRO cases being withdrawn or dismissed over a 2-year period, and only 11 of the 360 were from requesting pharmacies. Commenter stated House Bill 2600, passed in 2001, mandated the use of the IROs for medical necessity disputes and that this rule doesn't address the pharmacies' concerns.

RESPONSE: The commission acknowledges the commenter's recommendation for a pharmacy treatment guideline, but this recommendation is outside of the scope of this adopted rule. However, the commission is currently evaluating the need for treatment guidelines for medical services provided in the workers' compensation system. The commission disagrees that the purpose of the rule as adopted is to primarily address pharmacy disputes. The intent of the adopted rule is to resolve low-dollar disputes by any health care provider or injured employee for a nominal case review fee. In addition, the commenter's experience regarding pharmacy disputes is limited because the IRO fee prohibited more pharmacies from requesting IRO review. The commission agrees that HB-2600 passed during the 77th Legislative Session mandated the use of IROs for retrospective medical necessity disputes but it was not cost effective for pharmacies to request IRO review due to the low-dollar nature of pharmacy disputes. Therefore, in part, the Legislature during the 78th Legislative Session passed HB-3168, which allows the commission to develop by rule an alternate medical dispute resolution process for retrospective medical necessity disputes costing less than the cost of an IRO review.

COMMENT: Commenter opposed the proposed rule. Commenter stated the process as written is a summary judgment process when looked at from a legal perspective and that's the basis for the lawsuit that the commission and IROs spent over two years in.

RESPONSE: The commission disagrees that the adopted rule is a summary judgment process. The lawsuit referenced by the commenter involves the IRO rules and process that allows for an appeal to SOAH and to higher courts if necessary. The AMDR process is an expedited low-dollar dispute process for a nominal fee and no further appeal process is allowed.

COMMENT: Commenter stated that the proposed preamble is contradictory as it states it is difficult to obtain a letter of medical necessity from the prescribing doctor, yet the proposed rule requires documentation be obtained from the prescribing doctor.

RESPONSE: The commission disagrees that there is a contradiction in the proposal preamble and rule. Currently, obtaining a letter of medical necessity from a prescribing doctor can be difficult. This is rectified by the adoption of this rule that requires that a prescribing doctor provide the necessary supporting documentation for an AMDR dispute.

COMMENT: Commenters recommended the commission consider using IROs to provide an alternative dispute resolution process as this meets the constitutional challenges of the lawsuit faced by a particular IRO, and does not require additional staffing and budgetary expenditures. Commenter stated no existing IRO could pay a doctor to review and oversee a report for $100; however, several IROs are willing to try to review small dollar claim cases for a fee less than the present IRO Tier One and Tier Two fees. Commenters recommended the commission withdraw the proposed AMDR rule and amend §133.308, regarding Medical Dispute Resolution By Independent Review Organizations, to require a new tier for the review of retrospective medical necessity disputes where the amount in dispute is less than the tier one fee, rather than building a new system and provided the recommended language for the amendment of §133.308. Commenter stated the number of

the regular IRO cases would decline while the number of small dollar claim cases will increase.

RESPONSE: The commission disagrees that IROs should be utilized for the alternative medical dispute resolution process. HB-3168, allows the commission to develop by rule an alternate medical dispute resolution process for retrospective medical necessity disputes costing less than the cost of an IRO review. The intent of the AMDR process is for an expedited low-dollar dispute process at a nominal fee. In evaluating the use of IROs for the AMDR process the commission determined that utilizing doctors on the ADL would be more cost effective and would result in a pool of case reviewers willing to perform a review for the nominal fee. Therefore, the commission also disagrees with amending §133.308 as that rule is specifically for reviews by IROs. The commission clarifies that the number of regular IRO cases may decline and the number of low-dollar disputes may increase; however, the need for reviews by IROs will continue because HCPs must follow billing requirements which address bundling and unbundling of health care, and because it will not be cost effective for a health care provider to restructure their entire billing system in order to file several low-dollar disputes instead of filing one comprehensive IRO dispute.

The new rule is adopted under the following statutes: Texas Labor Code §402.061, which authorizes the commission to adopt rules necessary to administer the Act; Texas Labor Code §401.011, which provides general definitions used under the Act; Texas Labor Code §401.024, which provides the commission with authority to require use of facsimile or other electronic means to transmit information in the system; Texas Labor Code §402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form, manner, and procedure for transmission of information to the commission; Texas Labor Code §406.010, which authorizes the commission to adopt rules regarding claims service; Texas Labor Code §406.011, which allows the commission to require insurance carriers to designate an Austin representative to act as an agent for the insurance carrier and accept service on behalf of the carrier; Texas Labor Code §406.031, which holds an insurance carrier liable for compensation for an eligible employee's injury arising out of and in the course and scope of employment; Texas Labor Code §408.021, which provides that the injured employee is entitled to all health care reasonably required by the nature of the injury as and when needed; Texas Labor Code §408.023, which authorizes the commission to develop a list of approved doctors; Texas Labor Code §408.025, which authorizes the commission to adopt requirements for reports and records that are required to be filed with the commission by health care providers; Texas Labor Code §408.027, which provides for insurance carrier payment of health care providers; Texas Labor Code §409.003, which allows an employee or their representative to file a claim for compensation within one year from the date of injury; Texas Labor Code §409.009, which allows a person to become a sub-claimant to a workers' compensation claim; Texas Labor Code §409.021, which governs an insurance carrier's obligation regarding initiation of benefits; Texas Labor Code §409.041, which establishes the commission's Ombudsman program; Texas Labor Code §413.013, which authorizes the commission to establish programs for the retrospective review and resolution of disputes regarding health care treatments and services; Texas Labor Code §413.015, which directs insurance carrier payments to and audits of health care providers; Texas Labor Code §413.031 which directs medical dispute resolution; Texas Labor Code §413.042 which prohibits private claims; and Texas Civil Practice and Remedies Code, Chapter 146, which directs that health care providers submit bills no later than the 11th month in which the service was provided.

The previously cited sections of the Texas Labor Code are affected by this rule action. No other code, statute, or article is affected by this rule action.

§133.309. Alternate Medical Necessity Dispute Resolution by Case Review Doctor.

(a) Definitions. The following terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

(1) case review doctor--a commission selected doctor from the commission's Approved Doctor List assigned to conduct retrospective review of health care for medical necessity under this subsection.

(2) claim-specific--pertaining to one injured employee, a single workers' compensation claim filed by that injured employee, and a single insurance carrier (carrier), as defined in §133.1(a)(10) of this title (relating to Definitions for Chapter 133, Benefits--Medical Benefits), that has accepted liability for the claim.

(3) retrospective medical necessity dispute--a dispute regarding health care provided to an injured employee by a health care provider (HCP), as defined in §133.1(a)(9) of this title, for which reimbursement has been denied to an injured employee or HCP by the carrier based upon the carrier's determination that the health care is not medically necessary.

(b) Applicability.

(1) Alternate Medical Necessity Dispute Resolution by Case Review Doctor (AMDR) is the exclusive process to resolve claim-specific retrospective medical necessity disputes, wherein:

(A) the sum of disputed billed charges on a single bill is less than the tier one fee as established for the review of health care by an Independent Review Organization (IRO) (pursuant to Article 21.58C of the Texas Insurance Code); or

(B) the sum of disputed billed charges on multiple bills is less than the tier one fee as established for the review of health care by an IRO. Multiple billings may not include bills from more than one HCP.

(2) This rule applies to AMDR requests filed with the commission on or after October 1, 2004.

(3) The AMDR process is expressly limited to the resolution of retrospective medical necessity disputes as defined in paragraph (1)(A) and (B) of this subsection.

(4) This process shall not be utilized for the purpose of reviewing or appealing an IRO decision or a State Office of Administrative Hearings (SOAH) decision, nor pending decisions before those bodies, regarding retrospective medical necessity disputes.

(5) For medical services in which the sum of disputed billed charges, as determined in accordance with paragraph (1) of this subsection, is greater than or equal to the tier one fee for an IRO review or for requests received prior to October 1, 2004, the requesting party must file a separate request that adheres to the medical dispute process outlined in §133.308 of this title (relating to Medical Dispute Resolution By Independent Review Organizations).

(6) All disputes involving issues other than medical necessity shall be filed separately and processed under §133.307 of this title (relating to Medical Dispute Resolution of a Medical Fee Dispute)

and/or §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference).

(7) Where any terms or parts of this section or its application to any person or circumstance are determined by a court of competent jurisdiction to be invalid, the invalidity does not affect other provisions or applications of this section that can be given affect without the invalidated provision or application.

(c) Effect of Other Disputes.

(1) If, by the fifteenth day after the carrier receives the first written notice of the injury, the carrier has not disputed liability or compensability of the claimed injury, the carrier is liable for all medically necessary care that is provided for the claimed injury until the carrier timely disputes liability or compensability of that injury. A request for AMDR regarding the medical necessity of health care that was provided to treat the claimed injury prior to the carrier's dispute shall proceed to an AMDR final decision and order.

(2) If, by the sixtieth day after the carrier receives the first written notice of the injury, or a later day if there is a finding of evidence that could not reasonably have been discovered earlier, the carrier still has not disputed liability or compensability of the claimed injury, the carrier is liable for all medically necessary care that is provided for the claimed injury. A request for AMDR regarding the medical necessity of health care provided to treat the claimed injury shall proceed to an AMDR final decision and order.

(3) If the carrier timely disputes liability for the subject claim, denies compensability of the injury, or denies compensability of the body parts or conditions for which the health care in dispute was provided, AMDR will not proceed until after final adjudication by the commission finds liability and compensability for the injury.

(4) A request for AMDR regarding the medical necessity of health care provided for body parts or conditions already accepted by the carrier as to liability or compensability, or already adjudicated as to liability or compensability, shall proceed to a final decision and order.

(d) Parties. The following individuals shall be parties to an AMDR:

(1) the HCP who has been denied reimbursement for health care rendered;

(2) the prescribing/referring doctor, if that doctor is not the HCP who provided the care in dispute;

(3) the injured employee, if denied reimbursement for health care paid by the injured employee; and

(4) the carrier. The carrier participates in this process as a responding party and shall not be considered a requesting party.

(e) Timeliness. A request shall be filed with and received by the commission no later than one year from the disputed health care's date of service.

(1) A request by a HCP may be submitted only after exhaustion of the reconsideration process as established in §133.304 of this title (relating to Medical Payments and Denials).

(2) A request by an injured employee shall be initiated by contacting the commission in any manner for assistance with the AMDR requirements. The injured employee's initial contact establishes the date used to determine timeliness. The injured employee is not required to request reconsideration under §133.304 of this title.

(3) A party who fails to timely file a request waives the right to AMDR.

(f) Request by HCPs.

(1) Two copies of the request for AMDR shall be submitted to the commission in the form and manner prescribed by the commission.

(2) Each copy of the request shall be legible and shall include:

(A) a designation that the request is for AMDR;

(B) a copy of all medical bill(s) as originally submitted for reconsideration in accordance with §133.304 of this title;

(C) copies of written notices of adverse determinations from a carrier (both initial and on reconsideration) such as an explanation of benefits indicating that reimbursement is denied due to the health care not being medically necessary, or, if the carrier failed to respond to the request (either initial or on reconsideration), verifiable evidence or documentation of the carrier's receipt of the request; and

(D) a maximum of five single-sided documents, which may include a summary, supporting the medical necessity of disputed care, clearly identified as the documentation to be reviewed by the case review doctor. The prescribing/referring doctor shall provide the required documentation to the requesting HCP.

(g) Request by Injured Employee. Requests by the injured employee shall be legible and shall include:

(1) a designation that the request is for AMDR;

(2) documentation or evidence (such as itemized receipts) of the amount the injured employee paid the HCP;

(3) a copy of any written notice, if in the possession of the requestor, of adverse determinations from a carrier such as an explanation of benefits indicating that reimbursement is denied due to the health care not being medically necessary, or, if the carrier failed to respond to the request for reimbursement, verifiable evidence or documentation of the carrier's receipt of the request; and

(4) a maximum of five single-sided documents, which may include a summary, supporting the medical necessity of disputed care, clearly identified as the documentation to be reviewed by the case review doctor. The prescribing/referring doctor shall provide the required documentation to the injured employee.

(h) Assignment. The commission, within 10 days of receipt of a complete request for AMDR, shall assign a case review doctor to review and resolve the disputed medical necessity. The case review doctor will be selected, at the commission's discretion, from among commission-approved doctors having appropriate qualifications. The case review doctor shall be considered a doctor performing medical case review for purposes of §413.054 of the Act. The doctors utilized by the commission for this process will be of sufficient number to service the volume of AMDR requests. The case review doctor shall:

(1) be of the same or similar licensure as the prescribing/referring or performing doctor;

(2) have no known conflicts of interest with any of the providers known by the case review doctor to have examined, treated or reviewed records for the injured employee's injury claim;

(3) not have previously treated or examined the injured employee within the past 12 months, nor have examined or treated the injured employee with regard to a medical condition being evaluated in the AMDR request; and

(4) preserve the confidentiality of individual medical records as required by law. Written consent from the injured employee

is not required for the case review doctor to obtain medical records relevant to the review.

(i) Notification Order.

(1) The commission, also within 10 days of receipt of a complete request for AMDR, shall issue written notification to the parties which:

(A) indicates the case reviewer's name, license number, practice address, telephone number and fax number;

(B) explains the purpose of the case review;

(C) orders the requestor to pay the case review fee to the case review doctor no later than 14 days from the date of the order, unless the requestor is an injured employee, in which case the carrier is ordered to pay the case review fee; and

(D) advises the carrier to forward a written response to the case review doctor.

(2) The commission's notice to the carrier shall also include a copy of the AMDR request. The notice shall be forwarded to the carrier through its Austin representative. The carrier is deemed to have received the notification order and request for AMDR in accordance with §102.5(d) of this title (regarding General Rules for Written Communication to and from the Commission).

(3) Once the notification order has been issued, withdrawals by any party are not permitted.

(j) Case Review Fee. The AMDR case review fee is $100.00.

(1) An injured employee is never liable for the AMDR case review fee.

(2) The case review fee shall be initially paid by the requestor, unless the requestor is an injured employee, in which case the carrier pays the case review fee. Untimely payment of the case review fee will result in either:

(A) a dismissal of the requestor's AMDR request; or

(B) the issuance of an order to the carrier requiring payment of the case review fee when the requestor is an injured employee.

(3) Final liability for the AMDR case review fee shall be determined as provided in subsection (n) of this section.

(k) Carrier Response. No later than 14 days from the date of the notification order, the carrier shall submit directly to the case review doctor:

(1) the $100.00 case review fee with an annotation identifying the case review number, when required; and

(2) a written response by facsimile or electronic transmission, either explaining why the disputed health care is not medically necessary, or indicating that no documentation will be submitted for review. The response shall be limited to a maximum of five single-sided documents, which may include a summary, supporting the carrier's position. The carrier may elect to provide this written response. If the carrier elects to not provide a written response, the AMDR process will proceed to a final decision and order.

(l) Case Review. The case review doctor shall review up to five single-sided documents provided by each party.

(1) If a party's documentation exceeds the limit of a maximum of five single-sided documents, the case review doctor shall not review any of the offending party's documentation and the case review doctor shall indicate this in the report.

(2) If the case review doctor does not receive a timely response from the carrier, the case review doctor shall proceed with the review and issue the report required by subsection (m) of this section.

(3) To avoid undue influence on the case review doctor, any communication regarding the AMDR dispute between a party and the case review doctor, before, during, or after the review, is prohibited.

(4) Upon completion of the case review, the case review doctor shall maintain a copy of the report, all documentation submitted by the parties, the date the documentation was received and from whom, and the date and time the report was issued to, and received by, all parties. The case review doctor shall forward to the commission, upon request, copies of the retained information.

(m) Report. No later than five days after the date the carrier's response was due, the case review doctor shall issue a report addressing the medical necessity of the disputed health care.

(1) The report must include:

(A) the specific reasons for the case review doctor's determination, including the clinical basis for the decision;

(B) a description of, and the source of, the screening criteria that were utilized;

(C) a description of the qualifications of the case review doctor; and

(D) a certification by the case review doctor that no known conflicts of interest exist with any of the providers known by the case review doctor to have examined, treated or reviewed records for the injured employee's injury claim. The certification must also include a statement that the case review doctor has not previously treated or examined the injured employee within the past 12 months, nor has the case review doctor examined or treated the injured employee with regard to a medical condition being evaluated in the AMDR request.

(2) The case review doctor shall forward the completed report and a copy of the reviewed carrier's response to all parties and the commission.

(A) This information shall be forwarded to all parties and the commission by facsimile or electronic transmission.

(B) If the party is an injured employee and a facsimile number has not been provided, this information shall be provided by other verifiable means.

(3) Requests for clarification from the parties will not be accepted by the commission or the case review doctor. The commission, at its discretion, may seek clarification from the case review doctor and may require the case review doctor to issue an amended report within three days of the commission's request.

(n) Final Decision and Order. The case review doctor's report is deemed to be a commission decision and order, and is effective the date signed by the case review doctor.

(1) The decision and order is final and is not subject to further review.

(2) If the decision and order indicates that none of the disputed care was medically necessary, the decision and order will direct the prescribing/referring doctor to reimburse the requestor the case review fee only if the requestor is a pharmacy or durable medical equipment provider. No other parties shall reimburse, or be entitled to reimbursement of, the case review fee.

(3) If the decision and order indicates that any of the disputed care was medically necessary it will include an order that the carrier pay, in accordance with the commission's fee guidelines, for the care that was determined by the case review doctor to be medically necessary. The carrier will also be ordered to reimburse the requestor the case review fee.

(4) A party shall comply with the decision and order within 20 days of receipt.

(5) This final decision and order shall not be used by a carrier to prospectively deny future medical care.

(o) Dismissal. The commission may dismiss a request for AMDR if the commission determines that good cause exists.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

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CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER G. PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE

28 TAC §134.650

The Texas Workers' Compensation Commission (the commission) adopts new rule §134. 650, concerning Prospective Review of Medical Care Not Requiring Preauthorization (PRM process) with minor changes to the proposed text published in the March 5, 2004 issue of the *Texas Register* (29 TexReg 2195).

As required by the Government Code §2001.033(1), the commission's reasoned justification for this rule is set out in this order, which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the commission disagrees with some of the comments and proposals.

In addition to those received during the Public Comment period, comments were received at the Public Hearing held on April 14, 2004, the last day of the public comment period. Minor changes were made to the proposed rules in response to public comment.

The purpose of this new rule is to address the pretreatment impasse between insurance carriers and health care practitioners regarding health care that, by rule, does not require preauthorization, but is informally being denied in advance by insurance carriers on the basis of medical necessity and, in some instances, relatedness to the compensable injury. The new rule resolves the impasse by reality-testing the proposed care against the insurance carrier's position, first, by facilitating an active dialogue between the insurance carrier and the doctor proposing the care. If the dialogue breaks down, and resolution remains appropriate, the commission may then order a medical examination of the injured employee. If in the opinion of the examining doctor the proposed care is medically necessary and related to the compensable injury, an opportunity is provided for the parties to reach an agreement regarding the care. If negotiation fails at this point, the commission shall issue an interlocutory order to ensure that the injured employee receives prompt, appropriate and necessary medical care. An insurance carrier may later appeal the commission's interlocutory order.

The following benefits will result from implementation and enforcement of the rule as adopted:

* injured employees will be able to obtain prompt, appropriate and necessary medical care in situations where currently they are unable to;

* doctors and insurance carriers who are experiencing an impasse regarding issues of liability for medical care that is being proposed for the treatment of current conditions will have the opportunity to seek impartial, commission-authorized, third-party input regarding the proposed care;

* economic uncertainty for all parties regarding the future care for compensable injuries will be addressed among the parties through productive communication;

* parties will be properly motivated to timely pursue issues of extent of injury and relatedness of conditions to the compensable injuries;

* disputes affecting indemnity and medical benefits could be handled in tandem, thus reducing time, money and effort expended by commission staff and system participants since, in many instances, resolution of one dispute type ultimately affects the other;

* insurance carriers would be motivated to practice more efficient claims handling and avoid prospectively denying treatment without proper review of the claim and medical documentation;

* cost of providing care that would have later been determined through retrospective review to not be medically necessary can be avoided; and

* litigation expenses regarding disputes of medically necessity, particularly when the first opportunity to review medical necessity occurs only after the care has been provided, can also be avoided, including the commission's related SOAH costs.

The savings ultimately experienced through the opportunity provided by this rule for the early intervention in the decision-making process regarding appropriate medical care for the compensable injury will far outweigh the cost to carriers for the PRME examinations.

Participation in this process does not preclude simultaneous participation in dispute resolution regarding other compensability, indemnity, or income issues as provided in chapters 141 through 143 of the commission's rules. In fact, parties are particularly encouraged to pursue extent and relatedness issues as they arise as required by commission rule 124.3(c), and not wait for these considerations to hamper what may be necessary medical care and possibly delay or interfere with an injured employee's recovery.

There are changes to subsection (a) of the rule as proposed. New subsection (a) provides that the rule applies to a request for prospective review of the medical necessity of specific care where a factually substantiated rationale is provided which satisfies the commission that the insurance carrier intends to deny reimbursement for the proposed services. This change from proposal, embodied in new subsection (a)(2), clarifies that in order for a request for prospective review to be acted upon, more than mere speculation or inference on the part of the requestor is required to satisfy the commission regarding the carrier's intent to deny reimbursement. New subsection (a) also provides that the rule applies to any such request filed on or after October 1, 2004 from an injured employee or the injured employee's representative for a prospective review to be conducted regarding the medical necessity of specific care, which does not otherwise require preauthorization, being proposed for the treatment of the current medical condition for which the compensable injury is, or is suspected to be, a producing cause. The effective date of the rule was changed from August 1, 2004 as proposed to October 1, 2004 at the recommendation of commission staff to allow for infrastructure development and implementation of training.

There are no changes to subsection (b) of the rule as proposed. New subsection (b) provides that the parties to the process are: the injured employee or his representative as the person who initiates the request; the proposing doctor, who is the doctor proposing the specific care in question (also required is that the specific care proposed must be within that doctor's licensure authority); and the insurance carrier.

There are changes to subsection (c) of the rule as proposed. New subsection (c) provides that an injured employee initiates the process in the form and manner prescribed by the commission with the help of his doctor. The process will not continue to the next step without the active participation of the proposing doctor. The request for prospective review must include a description of the specific care being proposed, including the duration of the proposed care. Treatments that will be considered under the PRM process are limited in duration to one-month periods during the first three months following an injury. This limitation recognizes that doctors are usually seeing their patients at this frequency during the acute phases of an injury. This accommodates the need to allow for relatively quick intervention regarding ongoing treatment in connection with the development of diagnoses for the specific condition. After the first three months, the time limit is increased to three-month terms in recognition of conditions moving appropriately into longer-term, maintenance care. The process also requires the proposing doctor to provide a thorough explanation of why the care is medically necessary and how the compensable injury is a producing cause of the condition that is requiring care.

In response to comments regarding the treating doctor's role in the PRM process, the adopted rule contains a new provision in subsection (c)(1)(F) to indicate that the request must include confirmation that the treating doctor concurs with the treatment recommended by the proposing doctor prior to allowing the PRM process to be initiated.

The former subsection (c)(1)(F) has become new (c)(1)(G). This provision has been changed from proposal to require a requestor to provide a factually substantiated rationale which satisfies the commission that the insurance carrier intends to deny reimbursement for the proposed services. This clarifies that more than mere speculation or inference on the part of the requestor is required to satisfy the commission regarding the carrier's intent to deny reimbursement in accordance with changes to subsection (a). Finally, the proposing doctor must certify that he is not simply seeking a guarantee of payment for the sole purpose of avoiding the retrospective process currently in place pursuant to statute and commission rule.

There is no change to subsection (d) of the rule as proposed. New subsection (d) provides that the commission shall initiate facilitation of communication between the proposing doctor and the insurance carrier upon the receipt of a complete request. The commission will utilize a seven-day period to attempt to resolve the matter. The insurance carrier's participation in the facilitation efforts is voluntary. If the insurance carrier does elect to participate, resolution may be obtained by the insurance carrier agreeing to liability for the specific care proposed, or the proposing doctor and the insurance carrier mutually agreeing upon alternative specific care. This agreement would constitute voluntary certification for which the carrier will be liable regardless of any later determinations as to compensability or extent of injury.

If the parties are not able to reach a resolution by the seventh day from the date the commission receives the complete request, the commission may appoint a doctor to perform a Prospective Review Medical Examination (PRME). The commission has sole discretion in determining whether a PRME will be scheduled. If the commission determines that a PRME is not appropriate, the commission will notify the parties and provide a written rationale explaining its decision. The commission's decision to close out the request is not subject to review. At that point, the parties will have an opportunity to review the disputed care, and either modify the proposed care and initiate a new request for prospective review, or provide the care and pursue retrospective review if the insurance carrier denies payment for the submitted bill.

There are changes to subsection (e) of the rule as proposed. New subsection (e) details the PRME process in the event that the commission elects to appoint a doctor to review the proposed care. The selected doctor will be known as the PRME doctor and is designated as such to distinguish him from routine RME doctors. A scheduling order will be issued to the parties by the seventh day after the date the commission received the complete request. The commission anticipates that the examination will be scheduled to occur approximately ten to fifteen days from the date of the scheduling order. The purpose of the abbreviated timeline is to ensure that appropriate and timely medical care for the compensable condition is provided to the injured employee. The scheduling order will ask the PRME doctor to address very specific, narrow questions to include whether the proposed care is medically necessary and, if applicable, whether the condition to be treated is causally related to the compensable injury. The PRME doctor will be directed to address only the questions asked and not to volunteer additional opinions regarding relatedness or propose alternative care options.

The proposing doctor and the insurance carrier will be directed by the scheduling order to send all relevant records, both medical and other appropriate records, to the PRME doctor and, simultaneously, to the opposing party. Records shall be sent in a manner to ensure they are received by the PRME doctor and the opposing party no later than five working days prior to the examination. Unlike the designated doctor process, the examination will still take place regardless of whether the PRME doctor has received records from the proposing doctor or the insurance carrier. The resulting opinion will have presumptive weight and may form the basis of a commission decision that is binding on the parties pending an appeal. Therefore, it is important to both the

proposing doctor and the insurance carrier to provide the PRME doctor with all relevant medical information in a timely manner. If the proposing doctor feels there is other medical documentation not in the doctor's possession that is needed for the PRME doctor to make an informed decision, it is the proposing doctor's responsibility to obtain that documentation and ensure that it is forwarded to the PRME doctor and the insurance carrier prior to the examination. In response to comments regarding the need for clarification of the reimbursement for this type of examination, the adopted rule contains new language in subsection (e)(1)(G) that provides this clarification from the commission's fee guidelines.

In response to comments regarding whether the designated doctor pool was the appropriate group to conduct PRM examinations, the adopted rule contains a change in subsection (e)(1) to provide that the PRME doctors will be selected from the approved doctor list. It should be noted that the doctor selected from the ADL is not obligated to participate in this process, as it is voluntary. If an ADL doctor does not wish to participate in the prospective review process, this will not subject the doctor to removal from any of the commission's doctor lists. Additionally, the strict requirements regarding scope of practice used in the designated doctor process will not be applied to prospective review of medical care. The commission shall select a doctor from the ADL who is of the same or similar licensure as the proposing doctor.

The commission shall use the same doctor for all subsequent requests for review on that claim if the doctor is still qualified and available in order to maintain consistency. A doctor would be replaced, however, if he has treated or examined the claimant outside of the realm of the PRME within the twelve months prior to the PRME, or if the doctor has ever treated the injured employee for the condition he is being asked to evaluate. In connection with the PRME doctor pool being changed from the DDL to the ADL, subsection (e)(2)(B) no longer contains a reference to the disqualifying associations for designated doctors, as identified in commission rule 180.21. This provision has been replaced with an equivalent conflict provision. Furthermore, if the doctor no longer has the same or similar licensure as the proposing doctor, he remains subject to disqualification. It should also be noted that a doctor selected for the PRME process will not be eligible to be a designated doctor for the purposes of assigning MMI/IR or for assessing the injured employee's ability to return to work regarding this particular claim, as provided in commission rule 130.5.

To ensure the PRME doctor's impartiality, the new rule requires that the parties not contact the PRME doctor, verbally or in writing, before or after the examination, with the following limited exceptions: when the injured employee needs to reschedule the appointment due to a conflict; when the insurance carrier or the proposing doctor needs to confirm with the PRME doctor's office administrative personnel that records were received or confirm that the examination took place; or when the insurance carrier needs to confirm billing information for the cost of the examination with administrative personnel at the PRME doctor's office. All other communication must occur through appropriate commission staff. In the event that the PRME doctor feels additional information is required to make an informed decision regarding the proposed care, the PRME doctor may contact other healthcare providers involved with the claim.

Subsection (e) of the new rule also provides that only the commission may contact the PRME doctor to clarify issues regarding his opinion. In response to comments regarding the process for seeking clarification, subsection (e)(7) was amended to provide that the commission may seek clarification based on guidance from the Commission's Medical Advisor and staff, and that only the PRME doctor's opinion as clarified will be the basis of any further resolution efforts by the commission, be presumed correct and upheld upon review unless the great weight of other evidence indicates the clarified opinion is incorrect, or be the basis of a medical interlocutory order.

Please also note the language in new subsection (e) regarding the importance of the injured employee attending the PRME examination or promptly rescheduling the appointment if there is a conflict. Failure to attend the examination would further delay receipt of the care that is being sought. Additionally, if an injured employee fails to attend or call to reschedule the appointment, the insurance carrier may stop the payment of temporary income benefits (if applicable pursuant to Texas Labor Code §408.004) until the injured employee does submit to the examination.

Additionally, the issued opinion and the medical records that were received for the examination are to be kept by the PRME doctor in the same manner as required of the designated doctors in the MMI/IR examination process. It is important for the doctor to maintain the actual records as it is anticipated the injured employee may return to the same doctor more than once to address subsequent issues of the necessity of proposed medical care. The doctor's maintenance of the records will ensure continuity between examinations and will reduce the need to repeatedly provide duplicate copies of records that have already been provided. Record keeping requirements identified do not exceed the general record keeping requirements in accordance with those of a doctor's respective licensing authority.

There are no changes to subsection (f) on the rule as proposed. New subsection (f) provides for resolution after completing a PRME. The PRME doctor shall provide a written opinion in the form and manner required by the commission within five days after the examination. The opinion shall specifically address the questions that were posed to the PRME doctor by the commission. The PRME doctor is to refrain from opining on any other issues or treatment options. The written opinion is required to be forwarded to the commission, the injured employee, the injured employee's representative (if any), the proposing doctor and the insurance carrier by personal delivery, mail, fax or electronic transmission. The specific means of delivery is left to the doctor's discretion, but must be made in a way that is verifiable.

Upon receipt of the PRME opinion, only the commission may contact the PRME doctor for clarification if the PRME doctor did not fully or clearly answer the questions posed, or if the PRME doctor included information that was not requested. This contact will be made solely at the commission's discretion. Commission staff will consult medical resources in the commission's central office if there is question regarding whether the PRME's opinion is clear and appropriately responsive. If medical clarification is sought from the PRME doctor, the commission will not issue an interlocutory order regarding the proposed care until the commission is satisfied that the opinion regarding the proposed care has been appropriately clarified. Requests for clarification or submission of additional documentation by the parties will not be accepted. It is important that the parties provide all the information they wish to be taken into consideration in a clear and concise manner prior to the examination.

If it is the PRME doctor's opinion that the proposed care is not medically necessary and/or not related to the compensable injury, the commission will take no further action regarding the proposed care. The proposing doctor may elect to provide the care anyway and utilize the retrospective review option if the carrier denies the bill. Or, the proposing doctor may choose to pursue alternative treatment options and repeat the PRM process. It is anticipated the PRM process will eliminate the impasse that currently occurs by reality-testing the proposing doctor's specific care and the insurance carrier's position, and encouraging the proposing doctor, injured employee, and insurance carrier to consider other care options, thereby allowing the injured employee to obtain appropriate treatment in a timelier manner.

If the parties are at odds regarding whether the condition proposed to be treated is related to the compensable injury, and the PRME doctor was directed to indicate his or her opinion regarding that issue, the parties may pursue dispute resolution as outlined in chapters 141 through 143 of the commission's rules. In fact, it is expected that any dispute over relatedness or extent of injury would have been identified and dispute resolution begun prior to, or concurrent with, this process. The PRME doctor's opinion regarding relatedness shall have presumptive weight that can only be overcome by the great weight of other medical or factual evidence in the pursuit of a resolution of this issue.

Also in new subsection (f), the proposed rule provides that if the PRME doctor opines that the proposed care is medically necessary (and, in situations where relatedness is at issue and the PRME doctor's opinion is that the compensable injury is the producing cause for the condition the proposed care is intended to treat), the commission shall facilitate communication between the parties and seek a written agreement from the insurance carrier that it is liable for the specific care identified by the PRME doctor as medically necessary. If the carrier agrees to accept liability for the proposed care via a written agreement, pursuant to §413.014(e) of the Act, it shall not later refuse payment based on there being an unresolved issue of medical necessity or relatedness. However, like the rest of the PRM process, participation in the agreement aspect is voluntary, and the insurance carrier is not required to participate and agree in writing to accept liability for the care identified by the PRME doctor to be medically necessary. Nevertheless, it is hoped insurance carriers will choose to participate, as the process provides helpful tools that would enhance insurance carriers' appropriate claims handling in general. Additionally, a pattern of repeatedly refusing to agree to liability for care that is medically necessary to treat the effects of a compensable injury could be indicative of practices that violate §408.021 of the Act.

There are changes to subsection (g) of the rule as proposed. New subsection (g) of the proposed rule provides that if the carrier elects not to voluntarily accept liability for the proposed care in spite of the PRME doctor's opinion, the commission shall issue a medical interlocutory order requiring payment within the commission's fee guidelines for the proposed care. In response to comments regarding the need for additional compliance language, subsection (g)(1) has been changed to provide consistency with commission rule 133.306. The new rule provides that the carrier shall comply with the order by the seventh day after receipt of the order and shall pay medical benefits in accordance with the order as and when they accrue. To clarify regarding the 45-day period for carriers to process billing, the new rule provides that once the medical service has been provided and the bill submitted to the carrier, the carrier is required to pay the bill, in the appropriate amount provided under the Medical Fee Guidelines, within 45 days of receipt in accordance with commission rule 133.304. The insurance carrier is prohibited by the interlocutory order from denying reimbursement on the basis of medical necessity or relatedness issues. It is understood that the care may be provided and billed by a health care practitioner other than the proposing doctor, such as a pharmacist, DME, or PT. The PRME's opinion regarding medical necessity carries presumptive weight and shall only be overcome by the great weight of other medical and/or factual evidence.

New Subsection (h) of the proposed rule provides that if the commission elects to issue a medical interlocutory order, that order is appealable to the State Office of Administrative Hearings (SOAH) pursuant to §413.055 of the Act. An insurance carrier has twenty days from the date the medical interlocutory order was received to file an appeal. Appeals must be filed with the commission's Chief Clerk of Proceedings pursuant to commission rule 148.3 and a copy sent to all other parties involved.

New Subsection (i) of the proposed rule provides that if a medical interlocutory order that has been issued by the commission is later overturned by a decision from SOAH, the insurance carrier may seek reimbursement from the commission's Subsequent Injury Fund pursuant to the procedure provided in commission rule 116.11.

New Subsection (j) of the proposed rule indicates that the commission will review the outcomes of the Prospective Review Medical Examination (PRME). If a pattern and practice of a doctor proposing and pursuing care that is determined in the PRM process to not be medically necessary becomes apparent, or if a pattern and practice of an insurance carrier declining to agree to accept liability for care that is determined in the PRM process to be medically necessary for the treatment of the compensable injury becomes apparent, the commission will take appropriate administrative action. Several groups and individuals submitted comments making recommendations, and/or supporting portions and opposing portions.

Comments expressing general support for amended §134.650 were received from the following groups or associations: Healthview, Southwestern Pain Institute.

Comments expressing general opposition to amended §134.650 were received from the following groups or associations: Anchor Claims Management, City of San Angelo, Temple-Inland, Inc., The Combined Group, Zurich Insurance, TASB, Texas Mutual Ins. Co., Envoy Medical Systems, American Insurance Association, Independent Review Inc., Insurance Council of Texas, Property Casualty Insurers Association of America, Doctors Guild of Texas. Comments expressing general concerns and/or making recommendations for changes to the rule language were received from the following groups or associations: CMI Barron Risk Management, PRS Inc., Texas Medical Management Inc. Summaries of the comments and Commission responses are as follows:

COMMENT: Commenter points out that rule 134.650 (e)(1)(G) requires an insurance carrier to pay for the PRME exam in accordance with the fee guidelines; however, the fee guidelines do not reference this type of examination. Commenter suggests either referencing the particular section of the MFG that this examination would fall under (i.e. RMEs) or including the billing information within the rule in the same manner as rule 129.5 (i).

RESPONSE: The Commission agrees. The rule is amended to reflect appropriate guidance regarding the billing and reimbursement for these examinations. Pursuant to the Commission's Medical Fee Guideline Training Module, when conducting an examination requested by the commission for a purpose other than certifying MMI and/or assigning an IR (e.g., a medical necessity issue), the following billing and reimbursement guidelines apply: 1) the examining doctor bills and is reimbursed using the "work related or medical disability examination by other than the treating physician" CPT code; the examining doctor uses the modifier "RE."; reimbursement is currently $350.00 and includes commission-required reports; required testing is billed using the appropriate CPT codes and is reimbursed in addition to the examination fee.

COMMENT: Commenter points out that $350 for an exam is significant; therefore there should be a minimum dollar threshold before prospective review could be requested. Commenter also points out this does not take into account the additional costs associated with copying and sending the file to the reviewing doctor or for the doctor advisor that would be discussing the case through the facilitation process prior to a PRME be ordered. Commenter indicates that it would be cost prohibitive to go through this process on low dollar treatment, causing carriers to pay for questionable treatment without review, which would run up medical costs.

RESPONSE: The Commission disagrees. While the reimbursement amount is currently $350 for this type of examination, it is significantly less than the $650 fee for retrospective review of the medical necessity of care that has already been provided. One of the most common complaints regarding the IRO retrospective review process is the high cost of the review compared to the low cost of the care (a particular example is in the case of prescription medication denials). Additionally, if it is ultimately going to be determined that care is not medically necessary, making that determination at the cost of $350 before it is provided whenever reasonably possible is obviously better than making that determination at the cost of $650 after it is provided.

The Commission also disagrees with the suggestion that a minimum dollar amount be established for the care in question to qualify for this prospective review. The process is designed to address situations where prospective denials are at issue, regardless of the cost of the care in question. The prospective denial of relatively inexpensive, yet very important when medically necessary, prescriptions is an example of that type of situation.

Finally, the Commission disagrees with the commenter's position that the cost of the prospective review will have the effect of driving carriers to pay for questionable treatment without review. The converse is true: the prospective review process provides a safeguard for the carrier who truly believes that the proposed care is not medically necessary. The reviewing PRME doctor's opinion could be in agreement with the carrier's doctor advisor's opinion, and no interlocutory order to pay for the care would issue. In the unlikely event that the care is provided anyway, the billing is still subject to retrospective review. If the Commission issues a medical interlocutory order to pay for specific care based on the PRME's medical opinion that the care is medically necessary, the carrier has the opportunity to prove that opinion wrong in an appeal to SOAH, and if successful, seek reimbursement from the SIF. The parties would be exposed to the same costs such as making copies in the prospective review process as they would be in seeking retrospective review.

COMMENT: Several Commenters indicated that the Commission lacks statutory authority to enact Rule 134.650 as there is no legislative mandate for this process. Conversely, a number of other Commenters pointed out that the Act and rules already have numerous provisions that allow for the Commission to order RMEs to address healthcare and to use Interlocutory Orders for payment of essential medical care, so this rule is unnecessary rulemaking of a function that could be accomplished with procedures alone. Yet another Commenter questioned the development of a rule to address such a small number of claims where the issue of prospective denials has been raised as problematic. Although for diametrically opposed reasons, all of these comments suggest that this rule places a greater workload and cost on the system and is not justified.

RESPONSE: The Commission agrees in part. While there has been no specific legislative mandate to establish the PRM process, TWCC has been directed to take steps to address rising medical costs, improve return to work outcomes, and improve the dispute resolution system. As such, it is inferred that the Commission has been mandated to take proactive steps in this area, such as in addressing prospective denials of medical care. Further, the Commission agrees that the statutory authority to adopt this rule and implement this process does exist in that, as pointed out by several commenters, there are already several provisions within the Act and rules that are being consolidated in the application of this rule. Additionally, the Commission has been criticized by the 5th Circuit Court of Appeals in their decision in Gregson v. Zurich American Insurance Company, 322 F.3d 883, for failing to provide an administrative process to address issues of prospective denial of medical care. The development of this rule establishes a process so that proposed care can be reviewed prospectively when appropriate, and there can be a sufficient basis upon which to issue a medical interlocutory order if the situation calls for one.

The Commission disagrees with the contention that the process will generate a greater workload or increase the overall cost to the system, as these proposals for care are already being made and addressed in other, less productive ways by the system participants as well as Commission staff, and by resolving these issues earlier on in the process rather than resorting to expensive, lengthy, and burdensome retrospective review should have the opposite effect, which would be reducing costs to the system overall.

COMMENT: Commenters indicate the Commission does not have jurisdiction to issue this type of interlocutory order, pointing to sections of the labor code addressing who may enter such orders.

RESPONSE: The Commission disagrees with the interpretation that only benefit review officers, contested case hearing officers and the executive director may issue interlocutory orders. Texas Labor Code Section 413.055 provides that the executive director, as provided by commission rule, may enter an interlocutory order for the payment of all or part of medical benefits. The order may address accrued benefits, future benefits, or both accrued benefits and future benefits. Section 402.042(b)(12) states that the executive director may delegate all powers and duties as necessary. Rule 133.306(a) provides that the executive director may delegate the authority to issue interlocutory orders for accrued and/or future medical benefits to Medical Review Division staff, and (c) states that the Commission shall enter an interlocutory

order only when, absent the interlocutory order, the injured employee would not receive essential medical treatment. The commission believes that is has sufficient authority for the executive director to delegate the responsibility to issue medical interlocutory orders under new Rule 134.650 to appropriate staff.

COMMENT: Commenter indicates general support of the rule, but requests further definition of what evidence is needed in order to get a claim reviewed.

RESPONSE: The Commission agrees the process is necessary but disagrees with the need for further definition. However, to emphasize the importance of the existence of a true impasse that is due to the carrier's intent to deny the care as not medically necessary and/or not related to the compensable injury, this factor is now included in subsection (a) relating to the applicability of the rule. Additionally, this factor has been revised in subsection (c) which defines what is necessary to begin the Prospective Review Process. Specifically, the injured employee and proposing doctor (with concurrence of the treating doctor if not the proposing doctor) are to provide information that includes: a description of the specific care and duration of care being proposed; an explanation of why the care is medically necessary; the basis of the doctor's opinion that the compensable injury is a producing cause of the condition requiring the care; and (as revised) a factually substantiated rationale which satisfies the commission that the insurance carrier intends to deny reimbursement for the proposed services. This revision clarifies that more than mere speculation or inference on the part of the requestor is required to satisfy the commission regarding the carrier's intent to deny reimbursement. However, the Commission will not limit the types of evidence that can be considered to meet this standard by further definition. This process is not for the purpose of seeking prospective guarantees and avoiding entirely the retrospective review process. In the current paradigm of medical necessity reviews, there are situations where retrospective review is not overly burdensome to the healthcare providers and does not interfere with the timely delivery of appropriate medical care. However, when it is clear that breakdown in communication between health care providers and carriers detrimentally interfere with timely and appropriate delivery of health care, the commission must have a mechanism to jumpstart communications that will lead to appropriate and timely determinations of what care is medically necessary to treat a compensable injury.

COMMENT: A Commenter questioned why Rule 134.650 required the doctor to submit two separate forms of documentation to make a case regarding care, one set for the injured employee to initiate the process and then another set to send to the insurance carrier and the Commission.

RESPONSE: The Commission disagrees with the Commenter's assessment. The doctor is not required to submit different pieces of information. The documentation the injured employee provides to initiate the request for review comes from the proposing doctor. That documentation is to be provided from the proposing doctor to the commission and the carrier at the same time. By providing a copy to the carrier, the carrier is made aware that the process has been initiated.

COMMENT: Several Commenters indicated that Rule 134.650 would undermine the independent review organization process that is already in place as mandated by the legislature in HB-2600. One Commenter suggests that a paper review by an IRO is less intrusive into the doctor patient relationship than adding doctor's examination opinion and is also less expensive.

RESPONSE: The Commission disagrees. The IRO process is not designed to address prospectively the possible courses of treatment that do not require preauthorization, but are proposed and bear discussion prior to being provided. The physical examination of the injured employee is necessary to give an appropriate assessment of the condition and the medical necessity of the proposed care. The commission believes that a physical examination is also a necessary component to a medical opinion upon which to base a medical interlocutory order that subjects the Subsequent Injury Fund to exposure for reimbursement.

COMMENT: Commenter supports the new rule, indicating it is in the best interest of both the injured employee and the insurance carrier to use an independent examiner with an unbiased opinion to resolve questions.

RESPONSE: The Commission agrees. When there is an impasse between the insurance carrier's medical personnel and the injured employee's doctors regarding proposed medical care, an independent examination from a commission-selected doctor may be appropriate to assist the parties in determining the proper course of treatment to avoid costly delays of timely and medically necessary care, as well as the other extreme, costly over-utilization.

COMMENT: Commenters expressed concern regarding the impartiality of doctors that would be used for PRME examinations. Using doctors who are providing treatment within the system, the carrier has no guarantee that there will be an independent and objective review. Another commenter suggests that a doctor whose name is on the report is less likely to be independent and impartial because of the lack of confidentiality.

RESPONSE: The Commission disagrees. While the Commission understands the concerns regarding partiality, the only doctors available for a hands-on examination are doctors who are providing treatment within the system. The Commission does not contemplate development of a pool of doctors that do nothing but Commission examinations. This would bring about other concerns, such as whether doctors' care determinations are being reviewed by doctors that do not treat patients in a regular practice. Additionally, the Commission must consider doctor availability.

The Commission also disagrees that a doctor will be less impartial if the doctor is named in the report. This process is not similar to that of an IRO reviewer who is anonymous in that process. The doctor in this process will be conducting a physical examination of the patient, and the doctor's identity will by necessity be known.

COMMENT: Several commenters question the proposal that the designated doctors form the pool of doctors for PRM examinations and question whether there would be enough doctors in rural areas to provide the services necessary. Commenters also expressed concern about this group of doctors when there are documented instances of designated doctors not properly applying the AMA guidelines to provide valid impairment ratings.

RESPONSE: The Commission disagrees that there will be a shortage of doctors to perform PRM examinations. The interim PDM process has resulted in less than 500 examinations scheduled from August 2003 through March 2004. There has been no shortage of doctors available to conduct these examinations in the interim process. Additionally, to address the potential that the opportunity for an interlocutory order might increase the demand for PRM examinations, the rule has been changed to open

the field of eligible doctors for PRM examinations to any doctor on the ADL, rather than limiting it to the DDL.

COMMENT: Commenters object to the rule allowing PRME doctors to be selected from the same licensure without regard to scope of practice. Additionally, commenters point out that doctors tend to take affront if the review is done by someone other than a peer in the doctor's own field and area of expertise.

RESPONSE: The Commission disagrees. The PRME doctor will be responsible for addressing the appropriateness of the specific care being proposed, and if requested, the relatedness of the condition proposed to be treated to the compensable injury. Identical licensing and expertise are not required for a doctor to determine if, for example, physical therapy is medically necessary at that particular point in the injured employee's care. There is also the concern noted previously about having enough doctors available to perform the examinations. The stricter the requirements to stay within the proposing doctors specific scope of practice, the more limited the pool of potential, qualified PRME doctors. This would be counterproductive to the commission's responsibility to assure that the injured employee receives the care that is necessary in a timely manner so that the return to employment is not unnecessarily delayed.

COMMENT: Commenters indicated that the only reason providers would pursue the PRM process would be if they were concerned about not being paid and were seeking a guarantee of payment, which the commenters contend could imply that they too question the necessity of the care. Commenters further suggest that the rule could be perceived as an incentive for providers to seek prospective review in order to avoid the uncertainty of the retrospective review process and get a guarantee of payment, which could result in a significant increase in the number of requests for prospective review. On the other hand, one commenter stated that providers should have the right to seek a guarantee of payment for services and that the requirement that the provider must certify that he is not simply seeking a guarantee is out of line with the intent of prospective review.

RESPONSE: The Commission disagrees. Rule 134.650 is designed to address the relatively few instances where an injured employee cannot receive any care due to an impasse between the insurance carrier and the healthcare provider, such as in cases when the insurance carrier indicates that the injury has resolved and no further care of any type is required. However, to make it clear that the commission does not intend this rule to provide an opportunity to shop for a medical opinion that would support an interlocutory order and that a request for prospective review does not apply unless a factually substantiated rationale is provided which satisfies the commission that the insurance carrier intends to deny services, the rule as proposed has been modified in subsection (a) regarding applicability, and subsection (c) regarding request. The rule has been changed to clarify that more than mere speculation or inference on the part of the provider is required to satisfy the commission regarding the carrier's intent to deny reimbursement. It is also noted that during the interim process, there have been many instances where the examining doctor's opinion was that the proposed care was not medically necessary to treat a condition for which the compensable injury is the producing cause. It is the commission's opinion that this potential serves as a counter balance to the interest in seeking a guarantee. The Commission also disagrees with the commenter that stated that the provider should have the right to a guarantee. The statutory provisions of the workers compensation system provide for a retrospective review process. In order for this rule regarding the prospective review of medical care to apply, there must be a basis in fact satisfying the commission that an impasse between the health care provider and the carrier regarding the specific care in question exists; such as, but not limited to, an adverse peer review or documented communication with an adjuster.

COMMENT: A Commenter asserted that rule 134.650 would circumvent a carrier's right to retrospectively review care provided for medical necessity, which conflicts with Commission Rules chapter 133. Additionally, some commenters contended that providers who provide unnecessary treatment will continue to do so until limited by a carrier; and, that if, on the other hand, carriers are denying reasonable and necessary medical care, the commission should aggressively pursue penalties through compliance and practices. These commenters further contend that this new process will not be enforceable.

RESPONSE: The Commission disagrees. The PRME process was developed as a result of the continuing complaints from providers and injured employees regarding how impasses with carriers on appropriateness of care delays and prevents medically necessary care. Additionally, the 5th Circuit Court of Appeals' criticism of the Commission in Gregson v. Zurich American Insurance Company, 322 F.3d 883, for failing to provide an administrative process to address issues of prospective denial of medical care also focused the commission's attention on this issue. While over-utilization and inappropriate denials of medically necessary care are issues being addressed by the agency's oversight through the Medical Quality Review Panel and regulation through Compliances and Practices, there remains the obligation to provide an avenue for injured employees to address situations where an impasse regarding what care is appropriate for their compensable injury interferes with or interrupts prompt medical care that is necessary to ultimately return them to a productive state.

The PRME process is designed to assist injured employees to address relatedness and medical necessity issues prospectively when appropriate. Any medical interlocutory order that is issued is subject to appeal by the carrier to SOAH. Currently, without this process, an injured employee may go for months without appropriate treatment for a compensable condition while the carrier and the health care provider are unable to reach consensus on what treatment is necessary and appropriate. Until the impasse can be resolved, the care in question is perceived by the injured worker to be medically necessary for a condition that is a part of the compensable injury, whether it is or not. The resulting disruption creates animosity and further disputes, and increases the likelihood that the injured employee's return to work is further delayed, perhaps indefinitely. Disability management studies indicate that the longer an individual remains off work, the less likely it becomes that the individual will ever return to the active workforce.

COMMENT: Commenters indicate that the current practice of many insurance carriers is to simply verify that there is a claim and indicate whether or not there is a dispute, which does not provide the proposing doctor the explanation required in the rule of the circumstances that cause him to believe the services will not be paid. Another Commenter suggested that the rule clarify that the rationale for belief of non-payment be confined to the specific claim and not based on treatment protocols that are frequently denied across the board.

RESPONSE: The Commission disagrees that the carrier practice described will prevent a proposing doctor from being able to identify circumstances that are indicating a prospective denial. The Commission also disagrees that the process should be limited to address prospective denials based only on the specific claim and not on those where the doctor understands the carrier to be denying particular care across the board. The purpose of the information is to provide a basis in fact satisfying the commission that an impasse between the health care provider and the carrier regarding the specific care in question exists, which is one of the requirements necessary to trigger a prospective review. Additionally, the information gives an indication of the level and type of communication that has occurred between the provider and the carrier regarding the proposed care. Based on the anecdotal information derived from the interim process, the responsive information for this requirement will generally include, in addition to the carrier's response regarding coverage and dispute status, statements such as the following: the carrier provided or referenced a peer review that indicates no further treatment is required; the doctor has not been paid for services for some or all of the treatment already provided and billed; carrier advised that the proposed treatment is being denied across the board; or, carrier has disputed or indicated intent to dispute that the compensable injury extends to or includes the condition or body part subject of the proposed treatment.

COMMENT: Several Commenters assert concerns that the proposed rule 134.650 would circumvent the BRC/CCH dispute resolution process regarding issues of extent of injury, as the PRME would be the sole trier of facts. Emphasized is that the PRME's medical opinion is given presumptive weight, while extent of injury disputes often involve many facts beyond the strict medical questions. The claimant's version of the claim events, medical history and other factors would be what the PRME would rely on in making a decision. There would be little or no opportunity for the employer or carrier to present their evidence. A Commenter is concerned that the PRME doctor would not investigate beyond what the claimant and treating doctor provide and that the carrier would have little opportunity to provide contradictory evidence. Further, the PRME may be asked to address non-medical issues in which the doctor has no experience or training. It was also suggested that assigning presumptive weight to the PRME doctor's opinion in effect improperly delegates dispute resolution authority.

RESPONSE: The Commission disagrees. Rule 134.650 does not circumvent the dispute resolution process for issues of extent of injury. The effect of the rule is in fact the opposite, as it provides an opportunity for the parties to develop their positions regarding extent of injury in a timely and efficient way, so that disputes can be addressed and resolved at the least formal level possible. The rule encourages parties to promptly request dispute resolution when there are any compensability questions that need to be addressed, and allows for compensability or extent and intertwined medical necessity issues to be resolved concurrently.

While the PRME doctor's opinion is given presumptive weight, the rule does not render the doctor the "sole trier of facts" as suggested by the Commenter. The rule does not delegate dispute resolution, rather it provides a tool (that being an independent, unbiased medical opinion) to be utilized by parties in the dispute resolution process. Parties who disagree with the PRME doctor's opinion and are unable to resolve the matter informally through a benefit review conference will have the opportunity to present all contrary evidence (medical and other) at a contested case hearing to persuade the finder of fact (hearing officer) that the great weight of the other evidence overcomes the presumption that the PRME doctor's opinion regarding the compensability, relatedness, or extent of injury is correct.

Additionally, regarding the concern that the employer or carrier would have little or no opportunity to present their evidence regarding the extent issue, it is important to note that section (e) of the rule provides the insurance carrier the opportunity to provide any medical or other appropriate records to the PRME doctor for consideration in his review and evaluation of the injured employee. The keystone of the process is to provide all relevant information to the PRME doctor before the examination so that his opinion will be based on a complete assessment of the medical necessity and extent issues before him.

COMMENT: Several Commenters suggested that the insurance carrier should be able to seek clarification from the PRME doctor. Another suggestion is that the rule should allow contact with the PRM doctor, as it is not realistic to expect doctors not to contact each other. Others suggested that the insurance carrier should be allowed to include an analysis in the same form as for other designated doctor examinations, particularly since the opinion will carry presumptive weight.

RESPONSE: The Commission disagrees with allowing either party to request clarification from the PRME doctor. The PRM process is designed to be a streamlined review so the proposing doctor and the injured employee know promptly whether care is considered appropriate or if the care plan needs to be re-evaluated. Allowing the parties the opportunity to request clarification and potentially stall the process would defeat the purpose. However, the comments do highlight that the need to provide an avenue to obtain clarification is very important and should be medically based. Therefore, the rule is amended to clarify that commission will seek guidance from the Medical Advisor and his staff, and that only the opinion as clarified will be the basis of any further resolution efforts by the commission, be presumed correct and upheld upon review unless the great weight of other evidence indicates the clarified opinion is incorrect, or be the basis of a medical interlocutory order.

The Commission disagrees in part with allowing the participants to have direct contact with the PRM doctor. The commission notes that the rule provides for the PRME doctor to have the ability to initiate contact with any medical personnel that have been involved in the claim. Limiting the potential contact to only that which is initiated by the PRME doctor will maintain the goal of providing a streamlined, prompt evaluation and opinion. The commission also believes that it is important to limit contact with the PRME doctor in light of the need to protect the doctor's impartiality by not providing opportunities for undue influence to be exerted on the PRME doctor by other participants to the process.

The Commission agrees with the suggestion that the carrier be allowed to provide analyses such as those provided for designated doctor examinations. The commission believes that the rule as proposed for adoption provides for this in subsection (e) which states that the proposing doctor and the carrier are to forward to the PRME doctor all medical records and other appropriate records in their possession relating to the medical condition to be evaluated. Any analysis should inform the PRME doctor of relevant information that may not be obvious in other medical documentation, without resorting to suppositions or misrepresentation of facts. It is important that all pertinent information be provided to the PRME doctor prior to the examination, rather

than trying to change the doctor's mind with additional information later.

COMMENT: Several Commenters stated that, although Rule 134.600 explicitly states that voluntary certification is voluntary, the effect of the rule makes a voluntary process mandatory because failure to voluntarily certify treatment would trigger the PRM process. Another suggested that the only way to ensure compliance would be to change the references in the rule from "voluntary" to "mandatory". These comments recommended that a non-response from the carrier should be deemed a denial and should invoke an automatic interlocutory order for the carrier to be liable for the proposed medical care. Yet another Commenter suggests that if the carrier offers voluntary certification processes, that the provider be mandated to utilize this prior to requesting prospective review.

RESPONSE: The Commission disagrees. The rule assures that an insurance carrier retains the option of not participating in discussions regarding the appropriateness of care that does not require preauthorization prior to that care being provided. Exercising that option does not automatically trigger a PRM examination or an interlocutory order. The commission has discretion to not appoint a PRME doctor, and advise the participants of the reasons for that decision. When the commission does issue a medical interlocutory order pursuant to the PRM process, the carrier retains the opportunity to challenge the medical necessity of the care that has been provided under the interlocutory order. Therefore, the rights to voluntary certification and retrospective dispute resolution are both preserved.

The commission interprets the statute to preclude the suggestion that the rule expressly make the process mandatory. In following that interpretation, the commission disagrees that a non-response from the carrier should be deemed a denial and should invoke an automatic interlocutory order for the carrier to be liable. The same interpretation of the statutory constraints precludes the commission from agreeing that if a carrier offers voluntary certification processes, a provider should be mandated to utilize this prior to initiating the PRM process.

COMMENT: Commenter suggests that the same binding requirements of the rule should apply for both the carrier and the provider. As the rule is currently written, the insurance carrier is bound by the PRME doctor's opinion without appeal options if the opinion is that proposed care is medically necessary to treat a condition that is related to the compensable injury; however, the provider is not bound by the decision of the PRME doctor. The proposing doctor and resulting providers may proceed and submit a bill for retrospective review, even if the PRME doctor's opinion was adverse regarding medical necessity or relatedness. Conversely, another commenter questioned why the carrier was provided the option of participating in the facilitation, and the option to appeal the medical interlocutory order, while doctors who pursue the PRM process are not given the option to appeal a negative determination.

RESPONSE: The Commission disagrees with the assertion that the carrier is bound by the PRME doctor's opinion without appeal options if the opinion is that proposed care is medically necessary to treat a condition that is related to the compensable injury. The statute and the rule provide the carrier the right to appeal a medical interlocutory order directly to SOAH. Although the carrier will be liable for the care addressed under the medical interlocutory order pending that appeal, if it is successful in meeting the burden of overcoming the presumption that the PRME doctor's opinion regarding that care was correct by the great weight of other evidence, it may seek reimbursement from the Subsequent Injury Fund. Likewise, the carrier retains the opportunity to pursue an extent of injury dispute through the informal and formal indemnity dispute process.

The commission agrees in part with both points of equity raised by the commenters. It is the commission's opinion that the process addresses these issues fairly. While the doctor may proceed with treatment even if, in the PRME doctor's opinion, it is not medically necessary and/or proposed to treat a condition related to the compensable injury, there is no requirement that the carrier pay for the bill, and the carrier will have the benefit of the PRME opinion that is favorable to its position for purposes of the retrospective review and/or the indemnity dispute resolution process regarding the extent issue. It should also be noted that if the doctor was reluctant to provide the care and resorted to the PRM process for assistance in overcoming the impasse, it is unlikely that the doctor would continue to pursue that course of treatment in light of an adverse opinion of a PRME doctor. Doctors have the option to avail themselves of the PRM process or opt to provide the care in question and pursue medical dispute resolution if the insurance carrier does not reimburse the services. If a doctor elects to utilize the PRM process, and receives an unfavorable opinion, the doctor has the option of modifying the proposal to include care that can be agreed to by the parties or supported by a PRME doctor, if necessary.

COMMENT: Several Commenters asked what qualifications would be required of TWCC staff who were responsible for making determinations to set or not set PRME appointments. One Commenter recommends Commission staff members with medical qualifications make determinations on whether PRME is appropriate.

RESPONSE: The Commission agrees in part. The Commission will utilize disability resolution officers in processing PRME requests. The DROs will be operating under general guidance from the Medical Advisor and his staff, and the Medical Advisor's staff will be available for specific guidance if necessary.

COMMENT: Commenters recommended that there should be a cost to the requestor associated with the initiation of the PRM process in addition to the rule's requirement that the insurance carrier to pay for the examination. Commenters suggest that this would protect against abuses from doctors who over-utilize and might be inclined to descend upon the PRM process. One Commenter suggested that the party with whom the PRME doctor's opinion was not in favor should pay for the examination (loser pays).

RESPONSE: The Commission disagrees. It is appropriate for the carrier to bear the cost of an examination regarding the care for an injured worker's condition when the commission has determined that an examination should occur. The commission believes that the rule provides for appropriate discretion to protect the process from being abused as described by the commenters.

COMMENT: Commenter suggest that Rule 134.650(g)(1) should add five-day compliance language to the rule to bring the requirements for all interlocutory orders into harmony. Another Commenter points out that 133.306 allows compliance within seven days; however carrier's should still have their standard 45 days in order to process billing, especially if treatment had already been provided. Yet another Commenter indicated that the section does not make clear if the insurance carrier was required to make payment when billed or after dispute resolution.

RESPONSE: The Commission agrees. To provide further clarification, subsection (g)(1) has been changed to provide consistency with Rule 133.306. The new rule provides that the carrier shall comply with the order by the seventh day after receipt of the order and shall pay medical benefits in accordance with the order as and when they accrue. To clarify regarding the 45-day period for carriers to process billing, the new rule provides that once the medical service has been provided and the bill submitted to the carrier, the carrier is required to pay the bill, in the appropriate amount provided under the Medical Fee Guidelines, within 45 days of receipt in accordance with Rule 133.304. The insurance carrier is prohibited by the interlocutory order from denying reimbursement on the basis of medical necessity or relatedness issues. The commission also intends to place the compliance language on the interlocutory order itself.

COMMENT: Commenters requested clarification regarding the timeframes provided in Rule 134.650 (c)(1)(C)(i)-(ii). One suggested that since there were no timeframes when an agreement is reached between the insurance carrier and the doctor during any voluntary certification process there should be none required in this rule. Commenter also suggested that the 3-month time frame gives a false impression that a healthcare provider must request review of treatment every 3 months or that they have a 3-month approval which would not take into account changes necessitated by changes in the injured employee's condition. Another commenter suggested that early timeframes are unnecessary as little care is disputed in the first month of care and that 3-month intervals in later care was too long due to no latitude for changes due to improvement.

RESPONSE: The commission disagrees with the suggestion that the timeframes be eliminated because they are not required in the voluntary certification process, or that they be adjusted. The commission believes that although little care is disputed early on, timeframes are necessary for the situation when an impasse does occur. The 3-month period is a maximum not a minimum; therefore, it is anticipated that when appropriate in certain cases shorter periods will be addressed. Additionally, since this process may result in the Commission issuing a medical interlocutory order, the Commission has determined that specific, narrow timeframes of care are most appropriately addressed in this process in order to ensure that unsupportable exposure to SIF reimbursements can be avoided. Finally, the commission does not agree that doctors will be compelled to seek a review every 3 months or for plans that cover a minimum of 3 months. The PRM process is intended for use when a genuine impasse develops between the injured employee's health care provider and the insurance carrier, the commission does not envision scheduling PRMEs to facilitate routine approval of treatment plans.

COMMENT: Commenters stated that Rule 134.650 was merely a "workaround" for the real solution, which would be the adoption of treatment and disability management guidelines. One Commenter suggested there should be a policy of non-payment for treatment that falls outside of those treatments addressed by the medical fee guidelines (Rule 134.202). Another Commenter suggested the language of 134.650 (c)(1)(D)&(E) should be changed to include the phrase, "based on sound medical practice, principles, and standards; and, nationally accepted treatment guidelines" so that all proposals and plans would be based on the same standards and principles without ambiguity.

RESPONSE: The Commission agrees that treatment and disability management guidelines are components of a long-term solution to many of the issues currently facing the workers' compensation system in Texas. The Commission is currently developing treatment and disability management guidelines that the existing statutory framework can support. However, implementation of disability management will take some time, and the PRM process is designed to address this aspect in a manageable way in the interim. The suggestion that there should be a policy of non-payment for treatment that falls outside of those treatments addressed by the medical fee guidelines is outside the scope of the PRM process. Finally, the commission disagrees with the suggestion that the phrase, "based on sound medical practice, principles, and standards; and, nationally accepted treatment guidelines" will have the effect hoped for by the commenter. The adoption of a treatment guideline is also outside the scope of the PRM process.

COMMENT: Several Commenters suggested that Rule 134.600 regarding preauthorization be revised to include services that are consistently denied. The suggestions included giving clearer guidelines regarding what CPT codes require preauthorization and requiring preauthorization for chiropractic manipulation.

RESPONSE: The suggestions are outside the scope of the proposed PRM process.

COMMENT: Several Commenters recommended that the presumptive weight provision be removed, as there is no statutory provision that specifically assigns presumptive weight to the opinion from a commission-selected doctor regarding medical necessity of care or the relatedness. The occurrence of invalid impairment ratings is cited as an example of why the commission should not expand the presumption that a doctor's medical opinion is correct unless it can be overcome by the great weight of other evidence. The commenters point to the statutory provision in Chapter 410.165 that provides that the hearing officer is the sole judge of evidence, and similarly argue that this rule inappropriately imposes a standard of review upon SOAH hearing officers.

RESPONSE: The Commission disagrees. It is within the commission's authority to assign the standard of review for the weight to be attributed to evidence within the commission's dispute resolution framework, which includes the SOAH proceedings.

COMMENT: A Commenter points out that an insurance carrier would still pursue these medical decisions to SOAH if it disagrees with the PRME's decision, thereby incurring significant, additional costs.

RESPONSE: The Commission disagrees in part. The PRME doctor's opinion may concur with the insurance carrier's medical opinion, thereby eliminating the possibility of an appealable interlocutory order requiring the insurance carrier to pay for the treatment. If the PRME doctor's opinion is contrary of the insurance carrier's medical opinion, the carrier has the opportunity to re-evaluate its position on a case-by-case basis. If the carrier determines that it is necessary to pursue the appeal and is successful, the cost may be offset by a reimbursement from the SIF. The commission believes that the net result from this process, considered with the redistribution of costs attributable to retrospective disputes that should be realized, will not increase system costs, but will be more likely to decrease costs to a degree.

The Commission agrees that there could be some additional litigation costs if an insurance carrier appealed every medical interlocutory order or contested case hearing decision that finds against the carrier regarding an extent of injury issue under this rule. However, the cost would not arise as a result of this rule, but

rather from the carriers' business decision to litigate these decisions without fully evaluating rather than truly evaluating each case and the carrier's opinion regarding necessary care.

COMMENT: A Commenter suggests adding definitions for the terms "Maintenance care" and "Specific care" in order to ensure consistency within the Rules and ensure compliance. Also, the timeframe for negotiation should not begin until there is confirmation the insurance carrier had notice of the PRM request.

RESPONSE: The Commission disagrees with the need to add definitions regarding different types of care. The initial request for PRME already requires the doctor to specifically define the care that is being requested, including type, frequency, etc. Rule 134.650 is designed to address specific treatment recommendations regardless of what stage the claim is in when they are being requested. Additionally, while the documentation for the initiation is to be provided to the carrier at the same time it is provided to the Commission, the Commission shall initiate communication within a few days of receipt. The insurance carrier will have confirmation and will have 7 days in order to participate in discussions.

COMMENT: Commenters recommend that only the treating doctor be allowed to initiate the PRM process. Allowing the proposing doctor (if not the treating doctor) to initiate the process without the treating doctor's participation would conflict with the basic premise that the treating doctor is the primary care doctor/case manager responsible for management of the medical care on the claim.

RESPONSE: The Commission agrees in part. The Commission also sees the need for the treating doctor to be integrally involved in the process. However, this need must be balanced with the need to allow the doctor with the expertise explain the care being proposed. Therefore, 134.650 (c) is amended to indicate that the request must include confirmation that the treating doctor concurs with the treatment recommended by the proposing doctor prior to allowing the PRM process to be initiated.

COMMENT: A Commenter recommended that all parties should have to put any agreements in writing, even if voluntary, in order to avoid misunderstandings.

RESPONSE: while the Commission agrees that having the treatment agreed to specified in writing would help to avoid misunderstandings about what care is to be provided, the Commission is not in the position to mandate such practices in other rules outside of 134.650. The process being referred to is covered under 134.600 and is just as stated, a voluntary process. How the parties involved wish to go through this process is left up to them to work out.

COMMENT: Commenter indicates dissatisfaction with the system, as it appears the insurance carriers have more power and influence than other system participants. The Commenter questions why the focus is currently on providers without equal scrutiny of carrier practices and their alleged abuses.

RESPONSE: The Commission recognizes that there is a gulf between system participants, particularly health care providers and carriers. The commission believes that this rule is a step toward bridging that gap by encouraging communication.

COMMENT: A Commenter questions why Rule 134.650 (f) (2) states the Commission may not mandate an agreement by the carrier and suggests that the Commission do just that.

RESPONSE: The statute specifically provides for only voluntary certification of treatment plans; therefore, the commission does not interpret the statute to provide authority to mandate a carrier to certify treatment plans.

COMMENT: A Commenter questioned 134.650 (e)(1)(E), asking why the PRME doctor should not be allowed to share additional medical opinions.

RESPONSE: The rule limits the PRME's scope to the questions of relatedness and medical necessity in order to streamline the process. The purpose of this rule is not to establish wide-ranging treatment plans but to address the impasse regarding specific care options so that determinations regarding appropriate care can be made in a timely manner.

COMMENT: Commenter expressed opinion that the rule does not address the problem of it being necessary for doctors to explain and justify proposed care in terms that a lay-person (insurance adjuster) without medical background can understand.

RESPONSE: The Commission disagrees, as the carrier is required to utilize direction from utilization review or other medical expert resource in determinations to reject liability for care based on grounds of medical necessity.

The new rule is adopted under the following statutes: Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; Texas Labor Code §401.011, which provides general definitions used under the Act; Texas Labor Code §401.024, which provides the commission with authority to require use of facsimile or other electronic means to transmit information in the system; Texas Labor Code §402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form, manner, and procedure for transmission of information to the commission; Texas Labor Code §406.010, which authorizes the commission to adopt rules regarding claims service; Texas Labor Code §406.031, which holds an insurance carrier liable for compensation for an eligible employee's injury arising out of and in the course and scope of employment; Texas Labor Code §408.004, which allows the commission to require injured employees to submit to medical examinations to resolve questions regarding appropriate medical care and similar issues; Texas Labor Code §408.021, which provides that the injured employee is entitled to all health care reasonably required by the nature of the injury as and when needed; Texas Labor Code §408.023, which authorizes the commission to develop a list of approved doctors; Texas Labor Code §408.025, which authorizes the commission to adopt requirements for reports and records that are required to be filed with the commission by health care providers; Texas Labor Code §410.002, which allows the commission to resolve disputes regarding liability and compensability; Texas Labor Code §413.002, which authorizes the commission to monitor system participants for compliance with commission rules; Texas Labor Code §413.013 which allows the commission to establish programs for prospective review and resolution of a disputes regarding health care treatments and services; Texas Labor Code §413.014, which allows voluntary agreement to treatment including pharmaceuticals; Texas Labor Code §413.041, which requires commission approved doctors to disclose financial interests to screen for conflicts of interest; and Texas Labor Code §413.055, which allows the commission to issue medical interlocutory orders requiring carriers to be liable for specific future medical care.

The new rule is adopted pursuant to Texas Labor Code §§402.061, 401.011, 401.024, 402.042, 406.010, 406.031, 408.004, 408.021, 408.023, 408.025, 410.002, 413.002, 413.013, 413.014, 413.041, and 413.055.

§134.650. Prospective Review of Medical Care not Requiring Preauthorization.

(a) Applicability.

(1) This rule applies to any request from an injured employee or injured employee's representative for a prospective review to be conducted regarding the medical necessity of specific care, which does not otherwise require preauthorization, being proposed for the treatment of the current medical condition for which the compensable injury is, or is suspected to be, a producing cause.

(2) A request for a prospective review will not be acted upon unless a factually substantiated rationale is provided, which satisfies the commission that the insurance carrier intends to deny reimbursement for the proposed services.

(3) A dispute as to whether the compensable injury is a producing cause of the current medical condition that is the subject of the proposed care may be simultaneously pursued as outlined in Chapters 141 through 143 of this title.

(4) This rule applies to any request for review filed on or after October 1, 2004 regarding proposed care that has not yet been provided to the claimant.

(b) Parties. The following persons are parties to the prospective review of medical care process:

(1) the injured employee or the injured employee's representative as the initial requestor;

(2) the proposing doctor, who is the doctor proposing the specific care in question. The specific care proposed must be within that doctor's licensure authority; and

(3) the insurance carrier.

(c) Request.

(1) To initiate the prospective review process, the initial requestor must obtain written documentation, in the form and manner prescribed by the commission, from the injured employee's doctor who is proposing the specific care in question, that the compensable injury is a producing cause of the current medical condition that is the subject of the proposed care, and the proposed care is necessary to treat the subject condition. The documentation must contain:

(A) the proposing doctor's name and contact information (at a minimum, the proposing doctor's phone number, and either his fax number or email address);

(B) the injured employee's name and TWCC claim number;

(C) a description of the specific care and recommended number of sessions or the duration of care that the doctor is proposing:

(i) during the first three months from the date of injury, treatment proposed to be prospectively reviewed shall be limited to a maximum of one-month periods; and

(ii) after the first three months from the date of injury, treatment proposed to be prospectively reviewed shall be limited to a maximum of three-month periods.

(D) a thorough explanation of the medical necessity for the care being proposed;

(E) the basis for the doctor's opinion that the compensable injury is a producing cause of the current medical condition that is the subject of the proposed care;

(F) if the proposing doctor is not also the treating doctor, the signature of the injured employee's treating doctor, indicating the treating doctor's concurrence with the proposed care; and

(G) a factually substantiated rationale which satisfies the commission that the insurance carrier intends to deny reimbursement for the proposed services.

(2) The doctor's signature on the request for the prospective review process certifies that the review is being sought for the purpose of obtaining necessary medical care and not for the purpose of obtaining a guarantee of payment.

(3) The proposing doctor must simultaneously submit the documentation to the insurance carrier and the commission.

(d) Initiation of Facilitation.

(1) The commission shall initiate facilitation of communication between the proposing doctor and the insurance carrier upon receipt of a complete request for prospective review by the commission. The insurance carrier's participation in discussions is voluntary.

(2) Resolution may be obtained by:

(A) the insurance carrier agreeing to liability for specific care proposed; or

(B) the proposing doctor and insurance carrier mutually agreeing upon alternative specific care.

(3) If resolution is not obtained by the seventh day from the date the commission receives the complete request for prospective review, the commission may appoint a commission-approved doctor to perform a Prospective Review Medical Examination (PRME).

(4) If the commission determines that a PRME is not appropriate, the commission will notify the parties and provide a written rationale explaining its decision. The commission's decision to close out the request is not subject to review.

(e) Prospective Review Medical Examination.

(1) If the commission elects to appoint a commission-selected doctor from the Approved Doctor List to perform a PRME, the commission's written order assigning a PRME doctor shall:

(A) be issued to the parties by the seventh day after the commission receives the complete request for prospective review;

(B) indicate the PRME doctor's name, license number, practice address and telephone number, and the date and time of the examination;

(C) order the injured employee to be examined by the PRME doctor on the stated date and time;

(D) direct the PRME doctor to render an opinion on:

(i) whether the specific care proposed is medically necessary and, if applicable;

(ii) whether the compensable injury is a producing cause of the current medical condition that is the subject of the proposed care;

(E) direct the doctor to refrain from including any opinion or discussion regarding alternate care options;

(F) require the proposing doctor and insurance carrier to forward all medical records and other appropriate records in compliance with (e)(3) of this section; and

(G) require the insurance carrier to reimburse the PRME doctor for the examination in accordance with the commission's fee guidelines for conducting a return to work or evaluation of medical care examination requested by the commission. The following reimbursement guidelines apply: The PRME doctor is to bill and is to be reimbursed using the "work related or medical disability examination by other than the treating physician..." CPT code with the modifier, "RE."

(2) If at the time the request is made, the commission has previously assigned a PRME doctor to the claim, the commission shall use that doctor again, if the doctor is still qualified, as described in this subsection, and available. Otherwise, the commission shall select an available doctor from the commission's Approved Doctor List who:

(A) has not previously treated or examined the injured employee within the past twelve months and has not examined or treated the injured employee with regard to a medical condition being evaluated in the PRME;

(B) has no known conflicts of interest with any of the providers known by the PRME doctor to have examined, treated or reviewed records for the injured employee's injury claim; and

(C) has the same or similar licensure as the proposing doctor.

(3) The PRME doctor is authorized to receive the injured employee's confidential medical records to assist in the resolution of a dispute under this section without a signed release from the injured employee.

(A) The proposing doctor and the insurance carrier shall provide to the PRME doctor, and simultaneously to the opposing party, copies of all the injured employee's medical records and other appropriate records in their possession relating to the medical condition to be evaluated by the PRME doctor.

(B) The proposing doctor and the insurance carrier shall ensure that the required records are received by the PRME doctor and the opposing party no later than the fifth working day prior to the date of the PRME. Regardless of whether the PRME doctor receives any medical records from either the proposing doctor or the insurance carrier, the PRME doctor shall proceed with the examination of the claimant.

(4) To avoid undue influence on the PRME doctor, communication with the PRME doctor before or after the examination regarding the injured employee's medical condition or history may only be made through appropriate commission staff, except that:

(A) the PRME doctor may initiate communication with any doctor who has previously treated or examined the injured employee for the work-related injury or any doctor identified by the insurance carrier to have performed a peer review on the injured employee's claim;

(B) if a scheduling conflict exists, the PRME doctor or the injured employee who has the scheduling conflict must make contact with the other at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set for a date within seven days or as soon as possible after the originally scheduled examination;

(C) communication between the insurance carrier or the proposing doctor and administrative personnel at the PRME doctor's office is permitted for the limited purposes of confirming that records were received or to confirm that the examination took place; and

(D) communication between the insurance carrier and administrative personnel at the PRME doctor's office is permitted for the sole purpose of confirming billing information for the cost of the examination.

(5) If the injured employee fails to submit to the examination or fails to comply with (e)(5)(B) of this section regarding rescheduling the appointment, the insurance carrier may suspend temporary income benefits pursuant to §408.004 of the Act.

(A) If, after the insurance carrier suspends temporary income benefits, the employee submits to the PRME, the carrier shall reinitiate temporary income benefits as of the date the employee submitted to the examination.

(B) The re-initiation of temporary income benefits shall occur no later than the seventh day following the latter of:

(i) the date the insurance carrier was notified that the employee had attended the examination; or

(ii) the date the insurance carrier was notified that the commission found that the employee had good cause for failure to attend the examination.

(6) The PRME doctor shall provide a written opinion on the issues identified in (e)(1)(D)(i) and (ii) of this section within five days to the commission, the injured employee, the injured employee's representative (if any), the insurance carrier, and the proposing doctor by facsimile or electronic transmission if the PRME doctor has been provided the recipient's facsimile number; otherwise, the opinion shall be provided by other verifiable means.

(7) Requests from the parties for clarification from the PRME doctor will not be accepted. The commission may, at its own discretion based on guidance from the Commission's Medical Advisor and staff, contact a PRME doctor to clarify issues regarding his opinion. If clarification of the PRME doctor's opinion is sought by the commission, only the PRME doctor's opinion as clarified will be the basis of any further resolution efforts by the commission, be presumed correct and upheld upon review unless the great weight of other evidence indicates the clarified opinion is incorrect, or be the basis of a medical interlocutory order.

(8) The PRME doctor shall maintain in accordance with the record keeping requirements of the PRME doctor's licensing authority: a copy of the opinion; documentation of the date of the examination; the medical records reviewed; documentation of the date medical records were received and from whom; and the date, addresses, and means of delivery that the opinion was transmitted or mailed by the PRME doctor.

(f) Resolution.

(1) If the PRME doctor's opinion is that the compensable injury is not a producing cause of the current medical condition that is the subject of the proposed care and/or the proposed care is not medically necessary, the proposing doctor may:

(A) elect to provide care regardless of that opinion and pursue retrospective review of the bill if it is subsequently denied by the insurance carrier; or

(B) elect to pursue alternative care options.

(2) If the PRME doctor's opinion is that the compensable injury is a producing cause of the current medical condition that is the

subject of the proposed care and the proposed care is medically necessary, the commission shall seek a written agreement from the insurance carrier to be liable for the specific care. While the commission may not mandate an agreement by the insurance carrier, if an agreement is reached, the insurance carrier shall not dispute payment for the proposed care for reasons of medical necessity or compensability at a later date.

(3) If no written agreement regarding liability for the care identified in the PRME can be reached, the commission shall issue a medical interlocutory order under (g) of this section.

(4) If requested in the commission's scheduling order, the PRME doctor's opinion regarding whether the compensable injury is a producing cause of the current medical condition that is the subject of the proposed care, regardless of his opinion regarding whether the care is medically necessary, may form the basis of a request for a benefit review conference to resolve the issue of extent of injury pursuant to Chapters 141 through 143 of this title. The PRME opinion regarding whether the compensable injury is a producing cause of the current medical condition that is the subject of the proposed care is presumed to be correct and must be upheld upon review unless the great weight of other evidence indicates that the PRME opinion is incorrect.

(g) Medical Interlocutory Order.

(1) If the insurance carrier and the proposing doctor do not enter into a written agreement regarding liability based on the opinion of the PRME doctor, the commission shall issue a medical interlocutory order requiring payment in accordance with the commission's fee guidelines for the specific care identified as medically necessary by the PRME doctor. The carrier shall comply with the order by the seventh day after receipt of the order and shall pay medical benefits in accordance with the order as and when they accrue. Once the medical service has been provided and the bill submitted to the carrier, the carrier is required to pay the bill, in the appropriate amount provided under the Medical Fee Guidelines, within 45 days of receipt in accordance with §133.304 of this title (relating to Medical Payments and Denials). The insurance carrier is prohibited by the interlocutory order from denying reimbursement on the basis of medical necessity or relatedness issues.

(2) The PRME opinion regarding medical necessity, upon which the interlocutory order is based, is presumed to be correct and must be upheld upon review unless the great weight of other evidence indicates that the PRME opinion is incorrect.

(h) Appeal of Medical Interlocutory Order.

(1) The insurance carrier may appeal the medical interlocutory order by filing a written request for a SOAH hearing with the commission's Chief Clerk of Proceedings, Hearings Division, in accordance with §148.3 of this title (relating to Requesting a Hearing) pursuant to §413.055 of the Act.

(2) The request for a hearing to appeal the medical interlocutory order must be filed no later than 20 days from the date the order was issued and a copy of the request must be served on all other parties involved in the dispute. For purposes of this section, the proposing doctor is considered a party involved in the dispute and must be served.

(3) The commission shall file the request for a hearing with SOAH.

(4) The hearing shall be conducted by the State Office of Administrative Hearings within 90 days of receipt of a request for a hearing in the manner provided for a contested case under Chapter 2001, Government Code (the Administrative Procedure Act).

(5) Notwithstanding other provisions of this rule or any other rules, the acquiring, providing, assembling, filing and offering of documents at any *de novo* hearing (a new hearing based upon evidence admitted at the SOAH hearing) conducted by the State Office of Administrative Hearings, whether or not previously exchanged, is the responsibility of the requestor and respondent. The commission and the proposing doctor shall be co-respondents. Admission and use of such documents at the hearing are controlled by the procedural Rules of the State Office of Administrative Hearings. The commission will not file a copy of the PRM request, the PRME doctor's opinion, or medical and/or other records reviewed by the PRME doctor with SOAH or any party for a hearing scheduled to be conducted by SOAH.

(6) The parties to the dispute must represent themselves before SOAH.

(7) The insurance carrier shall not later dispute liability for the care based on medical necessity or compensability through any retrospective review process.

(8) A party who has exhausted the party's administrative remedies under the Act and who is aggrieved by a final decision of the State Office of Administrative Hearings may seek judicial review of the decision. Judicial review under this subsection shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

(9) The commission shall post the SOAH decision on the commission website after confidential information has been redacted.

(i) Subsequent Injury Fund. An insurance carrier that makes an overpayment pursuant to an interlocutory order may be eligible for reimbursement from the subsequent injury fund. An insurance carrier must make a request for reimbursement in accordance with §116.11 of this title (relating to Request for Reimbursement or Payment from the Subsequent Injury Fund).

(j) Compliance. If the commission believes that any person is in violation of the Act or this rule, the commission may initiate an appropriate compliance and enforcement action.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

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Susan Cory
General Counsel
Texas Workers' Compensation Commission
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For further information, please call: (512) 804-4287

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CHAPTER 165. REJECTED RISK: INJURY PREVENTION SERVICES

28 TAC §§165.1 - 165.3, 165.7

The Texas Workers' Compensation Commission (commission) adopts amendments to §§165.1, 165.2, 165.3, and 165.7, concerning Rejected Risk: Injury Prevention Services, with one change to the proposed text published in the April 30, 2004 issue of the *Texas Register* (29 TexReg 4073).

As required by the Government Code §2001.033(1), the commission's reasoned justification for these rules are set out in this order which includes the preamble, which in turn includes the rules. This preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rules, and the reasons why the commission disagrees with some of the comments and recommendations.

The amendments are adopted to replace references to the Texas Workers' Compensation Insurance Fund with references to Texas Mutual Insurance Company, correct certain references to the Texas Insurance Code, and remove an unnecessarily restrictive requirement for safety consultants.

The Texas Workers' Compensation Insurance Fund's name was changed to Texas Mutual Insurance Company by the 77th Texas Legislature in House Bill 3458 (HB-3458). The proposed changes would delete from §§165.1, 165.2, 165.3, and 165.7 all references to the Texas Workers' Compensation Insurance Fund or "the Fund" and replace them with Texas Mutual Insurance Company.

In addition, §165.1 is amended by changing certain references to the Texas Insurance Code, as a result of changes made to that statute by the 77th Texas Legislature in HB-3458.

Section 165.2 is also amended by deleting subsection (e), which requires a safety consultant to file a program review report with the commission within 24 hours of signature by the employer. This requirement is unnecessary because there is no demonstrated need to have the program review report filed within 24 hours of signature. Section 165.2(f) requires a safety consultant to file the report within 30 days after the policyholder receives notice of identification, and the 24-hour requirement does not further or otherwise enhance the commission's regulatory responsibilities within the Rejected Risk Requiring Injury Prevention Services Program.

Finally, the rules are amended by making certain minor grammatical and punctuation changes and changes for consistency purposes.

No changes are made to the proposed rules as a result of public comments received regarding the proposed amendments. However, one change is made to §165.2 by adding the word, "not," to the second sentence of subsection (c) to correct an inadvertent omission of this word in the text of the rule as proposed.

Comments regarding the proposed amendments were received from the following groups or associations: Texas Mutual Insurance Company; Edwards Risk Management, Inc.; and the Insurance Council of Texas. All comments were in support of the proposed amendments.

The amended rules are adopted pursuant to Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; Texas Insurance Code, art. 5.76-3, which establishes the Texas Mutual Insurance Company and sets forth certain functions and responsibilities of the commission in connection with the administration of an accident prevention program for policyholders of the Texas Mutual Insurance Company; and Texas Insurance Code, art. 5.76-4, which establishes the Texas Mutual Insurance Company as insurer of last resort for workers' compensation insurance and requires it to insure, subject to certain exceptions and at a higher premium, any risk that tenders the necessary premium and any applicable accident prevention service fees.

The amendments are adopted under Texas Labor Code, §402.061; and Texas Insurance Code, articles 5.76-3 and 5.76-4.

The previously cited sections of the Texas Labor Code and the Texas Insurance Code are affected by this rule action. No other code, statute, or article is affected by this rule action.

§165.1. Identification and Notification of Certain Policyholders Insured by the Texas Mutual Insurance Company Acting as the Insurer of Last Resort.

(a) The Texas Mutual Insurance Company shall provide a listing of the policyholders requiring accident prevention services (Rejected Risk employers) to the Texas Workers' Compensation Commission's Division of Worker's Health and Safety (the division). This list shall include those employers identified by the Texas Mutual Insurance Company through application of the criteria found in the Texas Insurance Code, art. 5.76-3, §8, and art. 5.76-4.

(b) A policyholder subject to the Texas Insurance Code, art. 5.76-3, §8(c) or §8(d), whose corporate office is located outside the state of Texas shall, upon receipt of notification by the Texas Mutual Insurance Company of the requirement to obtain a safety consultation as a condition of insurance, provide the Texas Mutual Insurance Company the following information:

(1) the name and title of the senior official in Texas with the authority to commit funds and to establish policy, procedures, and actions required to implement the accident prevention plan and address the exposures identified in the hazard exposure survey;

(2) the official's mailing address; and

(3) the official's business telephone number.

(c) Information required by subsection (b) of this section shall be mailed to the Texas Mutual Insurance Company at the appropriate address.

§165.2. Safety Consultation.

(a) Policyholders who have not had an accident prevention plan developed and implemented in the last six months prior to notification shall, not later than 30 days following the effective date of the policy, or receipt of notice of identification as a Rejected Risk employer, whichever occurs later, complete a safety consultation using a source approved by the division pursuant to §164.9 and §164.10 of this title (relating to Approval of Professional Sources for Safety Consultations; and Removal From the List of Approved Sources). The consultation may be provided by:

(1) the Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division);

(2) the Texas Mutual Insurance Company; or

(3) another professional source.

(b) Policyholders who have had an accident prevention plan developed and implemented within the six months prior to notification of their identification as a Rejected Risk employer must obtain division review of the plan for adequacy, to include an on-site visit.

(c) The division shall provide the Texas Mutual Insurance Company with a list of approved professional sources. If the Texas Mutual Insurance Company elects not to provide the policyholder with safety consultation and accident prevention plan development services, the Texas Mutual Insurance Company shall include a copy

of the list with the notification letter to the policyholder. If the Texas Mutual Insurance Company elects to provide such services, the list will be provided to the policyholder by the Texas Mutual Insurance Company at the request of the policyholder.

(d) The safety consultant, identified in subsection (a) of this section, shall visit the policyholder's work place, review existing safety programs, conduct a walk through at each appropriate job site to include a hazard exposure survey, and prepare a program review report. The report shall be in a written format prescribed by the commission.

(e) The initial program review report must be delivered to the division of Workers' Health and Safety no later than 30 days after the policyholder receives the notice of identification. An extension of 30 days may be obtained from the division for good cause.

(f) The safety consultants identified in subsection (a) of this section may charge the employer for consultations provided under this section.

§165.3. Formulation and Components of Accident Prevention Plan.

(a) Policyholders who have not had an accident prevention plan developed in the last six months prior to notification will, within 30 days of the date of the safety consultant's initial report, develop an accident prevention plan. This plan will be consistent with established state safety and health codes and with accepted industry practices. The accident prevention plan shall be developed with the assistance of an Approved Professional Source as defined in §164.9 of this title (relating to Approval of Professional Sources for Safety Consultations), and shall be in the format prescribed by the commission. The policyholder shall submit the completed accident prevention plan, developed and signed by the policyholder and the Approved Professional Source, to the division. The Approved Professional Source's signature on the accident prevention plan cover sheet certifies that the accident prevention plan meets the format prescribed by the commission. The format shall include the following components and specify the individual responsible for each, by position or title:

(1) a management component with a written safety policy statement and assignment of responsibilities and authority;

(2) analysis component which includes a review of safety program documentation, existing operations, and injury trends. The analysis will be used to evaluate the effectiveness of the existing programs and to detect existing or potential trends. The analysis component will contain a statement as to the interval between the accomplishment of the analyses;

(3) a safety program recordkeeping system component;

(4) a safety and health education and training component with a statement as to the interval between training sessions;

(5) a safety audit/inspection component with a statement as to the interval between safety audits/inspections;

(6) an accident investigation component to identify the cause factors of injuries, and plan and record corrective actions; and

(7) a component to ensure review and revision of the safety program when changes in operations, equipment, or employee activities are determined or anticipated, to ensure continued effectiveness of the program requirements. This component also includes the periodic review and revisions of the safety program including a statement as to the interval (minimum of annually) between reviews.

(b) Policyholders who have had an accident prevention plan developed and implemented within the six months prior to notification as a Rejected Risk Employer and verified and approved by the Texas Mutual Insurance Company or the Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division) will continue implementation of the plan and obtain an inspection by the division as provided in §165.6 of this title (relating to Follow-up Inspection by the Division).

(c) Reference material for the development of an accident prevention plan may be obtained from the division.

(d) An implementation time line, not to exceed three months after the formulation of the plan, shall be developed and included with the plan.

(e) If the policyholder disagrees with any or all of the plan, the policyholder shall sign the accident prevention plan cover sheet and attach a statement containing the specific reasons for disagreement to the plan and what alternative measures the policyholder proposes to meet the objectives of the program. The division will review the areas of disagreement and notify the policyholder and the safety consultant of the decision on each area of the disagreement.

(f) The policyholder's signature is understood to exclude those areas of the plan for which a disagreement has been attached to the plan, pending review by the division or a formal appeal.

(g) If the division finds it is practical to do so, the division may direct the policyholder to begin implementation of any or all parts of the plan that are not subject to the policyholder's disagreement. The time lines specified in the plan shall remain in effect for those parts of the plan the policyholder is directed to implement.

(h) The policyholder shall be responsible for filing the accident prevention plan that has been reviewed by the Approved Professional Source and signed as meeting the criteria in subsection (a) of this section with the division no later than 30 days after completion of the safety consultation and no later than 90 days after the policyholder received notification of identification as a Rejected Risk employer. Delays requested for good cause may be granted by the division.

§165.7. Report of Follow-Up Inspection.

(a) As soon as practical, but not later than 30 days from the date of the follow-up inspection, the policyholder, the safety consultant, and the Texas Mutual Insurance Company, shall be provided copies of the follow-up inspection report by the division.

(b) The report shall be in writing and shall specify whether the policyholder has, or has not, implemented the accident prevention plan or other acceptable corrective measures approved by the division.

(c) If the policyholder is found not to have implemented the accident prevention plan, the report shall also contain a list of the specific areas of the accident prevention plan which have not been implemented.

(d) Failure or refusal to implement the accident prevention plan is an administrative violation with penalty not to exceed $5,000 for each day of non-compliance. The Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division) shall refer the matter to the Commission's Division of Compliance and Practices to pursue the administrative violation if:

(1) the policyholder fails or refuses to implement the accident prevention plan or approved alternative measures;

(2) the policyholder does not cancel coverage within 30 days after the date of the division's determination of such failure or refusal; and

(3) the Texas Mutual Insurance Company notifies the division that it will not cancel the coverage.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 180. MONITORING AND ENFORCEMENT

SUBCHAPTER B. MEDICAL BENEFIT REGULATION

28 TAC §§180.20, 180.21, 180.27

The Texas Workers' Compensation Commission (the commission) adopts amendments to §180.20 (Commission Approved Doctor List), §180.21 (Commission Designated Doctor List), and §180.27 (Sanctions Process / Appeals / Restoration / Reinstatement) with minor changes to the proposed text published in the April 30, 2004 issue of the *Texas Register* (29 TexReg 4075).

As required by the Government Code §2001.033(1), the commission's reasoned justification for this rule is set out in this order, which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the commission agrees or disagrees with some of the comments and proposals.

Limited comments received during the Public Comment period did not alter the text of the adopted rule amendments. Minor changes were made to the amendments as proposed to bring the adopted amendments into compliance with *Texas Register* guidelines regarding form. Minor changes were also made to portions of the rules not subject to substantive amendment for purposes of form.

The purpose of the adopted amendments is to expedite commission actions to either delete a doctor from the commission's Approved Doctor List (ADL), or deny a doctor admission to the commission's Approved Doctor List (ADL) and/or Designated Doctor List (DDL), when the doctor's license has been revoked, suspended, or has not been renewed by the appropriate licensing or certification authority. The adopted amendments shorten the doctor's timeframe for responding to the commission's notice of intent from 15 days to five working days. The amendments also apply the accelerated timeframe to all grounds for Executive Director deletions made pursuant to §180.26(b) of this title and their parallel applications as bases for denial of admission to the ADL and/or DDL.

The rule amendments are adopted pursuant to the statutory provisions of House Bill 2600 (HB-2600), passed by the 77th Texas Legislature in its 2001 session, which made sweeping changes to the process by which a doctor's eligibility to practice within the Texas workers' compensation system was determined. Prior to HB-2600, Texas Labor Code §408.023(a) provided that each doctor licensed in this state on January 1, 1993 was on the commission's list of approved doctors unless subsequently deleted and not reinstated. HB-2600 changed this provision to require doctors to apply for admission to the approved doctor list and to meet commission adopted criteria regarding training, licensure, and disclosure of financial interests.

Executive Director Deletions From the Approved Doctors List (ADL)

In keeping with these greater list management responsibilities, the legislature, in Texas Labor Code §408.0231, authorized the commission's Executive Director to delete doctors from the approved list who fail to meet registration requirements, who are deceased, whose license to practice in this state is revoked, suspended, or not renewed by the appropriate licensing authority, and who voluntarily request removal from the list. To implement this charge, the commission adopted rule provisions at §§180.26(b) and 180.27(f) of this title. Subsection 180.26(b)(4) defined suspensions and revocations to include stays, deferments, and probations to set a high standard for system practitioners. Subsection 180.27(f) established the process by which doctors would be deleted by the Executive Director.

In the months following implementation of the commission's new ADL on September 1, 2003, it had come to the commission's attention that the 15-day period, allotted for a doctor to respond to a notice of intent to delete, unnecessarily delays the removal of a doctor who has lost all privileges to practice with the appropriate licensing or certification authority. Though deletions under these situations are somewhat academic (as the doctor may not legally practice), and risk to injured employees is accordingly minimized, the delayed removal can, in some scenarios, create billing problems for insurance carriers when the termination date for system participation lags behind the effective date of the licensing or certification authority's action. As noted above, subsection 180.26(b)(4) further requires removal of a doctor whose license suspension or revocation has been stayed, deferred, or probated by the licensing or certification authority. This higher standard eliminates the risk to injured employees from suspended or revoked doctors who may still legally practice under licensing board oversight, frequently with practice restrictions. Whether or not a doctor may practice, the adopted amendments to §180.27(f) shorten the doctor's timeframe for responding to the commission's notice of intent to delete from 15 days to five working days (as defined at §102.3(b) of this title (relating to Computation of Time)). Importantly, the level of due process afforded the doctor has not changed, it has merely been expedited by the rule amendments in these appropriate circumstances. The doctor is still afforded an opportunity to respond to the commission's notice of intent, and in these instances, extensive responses should not be necessary.

The other grounds for Executive Director deletions found at §180.26(b) are equally proper subjects for an accelerated deletion process. There is no basis for extending a voluntary request for removal or the academic removal of a deceased doctor's name from the list beyond a 5-working-day period. That timeframe and opportunity to respond is sufficient to ensure proper identification of the doctor. Similarly, a 5-working-day period affords a doctor sufficient time to correct any mistakes regarding training, testing and registration requirements under §180.26(b)(1) of this title.

The adopted rule amendment to §180.27 also clarifies the effective date of deletion for both a non-responsive doctor (the day following the fifth working day after the date the doctor received notice of intent, §180.27(f)(2)(A)) and a doctor whose response has not satisfied the Executive Director or designee (the day following the date the doctor receives notice of the deletion, §180.27(f)(2)(C)(ii)). Additionally, the rule amendment specifies the date of receipt for all notices as that established by methods found at §102.5(d) of this title.

In an effort to standardize time periods for doctor responses to proposed commission actions that are not subject to the proposed 5-working-day timeframe, the commission amends the 14-day period of §180.27(e)(1)(B) to 15 days.

Application of §180.26(b) Criteria to ADL and DDL Application Denials

The same rationales that underlie the accelerated timeframe for Executive Director deletions support proportionate changes to the response period for denials of applications for admission to the ADL and/or DDL. Unlike the rule amendments to §180.27, the recommended amendments to §§180.20(g) and 180.21(g) create a two-tiered response scheme for doctors: an accelerated 5-working-day period for application denials based on the same grounds given for deletions under §180.26(b); and the current 15-day period for all other denial grounds.

In implementing HB-2600, the commission adopted §180.20 of this title (relating to Commission Approved Doctor List) whereby the commission created the new ADL and rendered the prior list null and void. Similarly, the commission adopted §180.21 of this title (relating to Commission Designated Doctor List) to create registration and training requirements for designated doctors. Both rules provide criteria for denial of the application for admission to the respective lists. Importantly, the provisions at §§180.20(f)(3) and 180.21(f)(5) permit denial of an application based upon §180.26 criteria. Accordingly, the same grounds used for deletion from the ADL may be used to deny an application for admission to either list. Hence, the §180.26(b) criteria for Executive Director deletions (as discussed above) may be used for denial purposes. Further, the grounds which mandate denial of admission to the ADL at §180.20(f)(1) and to the DDL at §§180.21(f)(1)-(3) parallel the grounds for deletion found at §180.26(b)(1).

Consequently, the adopted rule amendments at §§180.20(g)(3) and 180.21(g)(3) incorporate the shortened 5-working-day response period for application denials based upon: a doctor's failure to complete required training and application requirements; a doctor's death; a doctor's voluntary request to withdraw the application; and significantly, the revocation, suspension or voluntary relinquishment of the license to practice. The same balance that was struck in the Executive Director deletion process between appropriate levels of due process and the commission's interest in ensuring the delivery of high quality health care applies to the application denial process.

Other issues addressed by the adopted amendments to §§180.20 and 180.21 include correcting the inconsistency between the 14 and 15-day time periods at §§180.20(g)(2) and 180.21(g)(2). The standard time period, as adopted, is 15 days. The adopted amendments to §§180.20 and 180.21 clarify the effective date of denial for both a non-responsive doctor (the day following the fifth working day after the date the doctor received notice of intent to deny, at §§180.20(g)(3)(A) and 180.21(g)(3)(A)) and a doctor whose response has not satisfied the commission (the day following the date the doctor receives notice of the denial, at §§180.20(g)(3)(B) and 180.21(g)(3)(B)). Finally, the rule amendments to §§180.20 and 180.21 specify the date of receipt for all notices as that established by methods found at §102.5(d) of this title.

Amendments to §180.20. Commission Approved Doctor List.

Minor changes were made to subsection (g) as proposed to bring the adopted amendments into compliance with *Texas Register* guidelines regarding form. Subsection (g) addresses the notification to a doctor of the commission's approval or denial of the doctor's application to the ADL. The adopted amendment added language to include approvals with condition(s) or restriction(s), harmonizing subsections (f) and (g). In addition, paragraph (g)(2) changes the timeframe for a doctor to respond to the denial or admission with condition(s) or restriction(s) to the ADL from 14 to 15 days, clarifying inconsistent provisions. Further, subparagraph (g)(2)(A) clarifies that the commission's notice shall be final effective the day following the 15-day response time. New adopted paragraph (g)(3) addresses denials issued in accordance with §180.20(f)(1) and §180.20 (f)(3) (where narrowly restricted to reliance on §180.26(b)). Subparagraph (g)(3)(A) establishes that if a response is not received by the fifth working day after the date the doctor received notice, the action shall be final effective the following day and no further notice shall be sent. Subparagraph (g)(3)(B) addresses the commission's final actions to a doctor's response which disagrees with the reason(s) given for the commission's denial to the ADL. If the commission's final decision is still a denial of the doctor's admission to the ADL, the commission shall provide the reasons for the denial. The denial shall be effective the day following the date the doctor receives notice of the denial. Adopted paragraph (g)(4), formerly (g)(3), clarifies that the date of receipt for notices shall be determined in accordance with §102.5(d) of this title.

Amendments to §180.21. Commission Designated Doctor List.

Minor changes were made to subsection (g) as proposed to bring the adopted amendments into compliance with *Texas Register* guidelines regarding form. Subsection (g) addresses the notification to a doctor of the commission's approval or denial of the doctor's application to the DDL. As adopted, paragraph (g)(2) changes the timeframe for a doctor to respond to the denial to the DDL from 14 to 15 days, clarifying inconsistent provisions. New adopted paragraph (g)(3) addresses denials issued in accordance with §§180.20(f)(1)-(3) and §180.20 (f)(5) (where narrowly restricted to reliance on §180.26(b)). Subparagraph (g)(3)(A) establishes that if a response is not received by the fifth working day after the date the doctor received notice, the action shall be final effective the following day and no further notice shall be sent. Adopted paragraph (g)(4), formerly (g)(3), clarifies that the date of receipt for notices shall be determined in accordance with §102.5(d) of this title.

Amendments to §180.27. Sanctions Process/Appeals/Restoration/Reinstatement.

There are no changes to subsection (e) from proposal. Subsection (e) specifies the reinstatement process for doctors under commission sanction. As adopted, subparagraph (e)(1)(B) changes the timeframe for a doctor to respond to commission notice of denied reinstatement from 14 to 15 days. This harmonizes the timeframe with other timeframes found in the adopted amendments to §§180.20, 180.21, and 180.27.

Minor changes were made to subsection (f) as proposed to bring the adopted amendments into compliance with *Texas Register* guidelines regarding form. Subsection (f) establishes the process by which the Executive Director deletes doctors from the ADL pursuant to §180.26(b). As adopted, subsection (f)(2) changes the timeframe for a doctor to respond to the deletion from 14 to five working days. Subparagraph (f)(2)(A) establishes that if a response is not received by the fifth working day after the date the doctor received notice of intent, the action shall be final effective the following day and no further notice shall be sent. Subparagraph (f)(2)(B) establishes that if the response is an agreement to the deletion, the doctor shall be deleted effective the earlier of the date the doctor agrees to the deletion or the day following the fifth working day after the date the doctor received the notice of intent and no subsequent notice shall be sent. Subparagraph (f)(2)(C) addresses the Executive Director's actions with respect to a doctor's timely response which disagrees with the reason(s) given for the Executive Director's deletion. Subparagraphs (f)(2)(C)(i) and (ii) state that if the Executive Director or designee determine that the grounds for deletion do not exist, the doctor shall be notified that he was not deleted; or, if the grounds for deletion do exist, the doctor shall be deleted effective the day following the date the doctor receives notice of the deletion. Adopted paragraph (f)(3) clarifies that the date of receipt for notices shall be determined in accordance with §102.5(d) of this title.

The commission's Medical Advisor reviewed and made recommendations regarding these adopted amendments.

Comment indicating support of the proposed amendments to §§180.20, 180.21 and 180.27 was received from the following group or association: Insurance Council of Texas.

Comment neither specifically opposing nor in favor of the proposed amendments to §§180.20, 180.21 and 180.27, but offering suggestions, was received from an unidentified commenter.

The comments and commission responses are summarized as follows:

COMMENT: Commenter stated support for the proposed amendments to Rules 180.20, 180.21, and 180.27.

RESPONSE: The commission agrees.

COMMENT: Commenter stated that the rule amendments would add further criteria to the currently sufficient requirements to become an approved doctor or designated doctor, increasing the risk of administrative error and discouraging good doctors from seeking to be system providers. Commenter recommended an incentive based program for doctors rather than restrictions. Commenter also recommended the commission focus on adjuster abuses of practice and getting the system under control. Commenter stated the commission should follow up on unethical behavior such as the commission taking 2.2 million dollars from an insurance company they regulate.

RESPONSE: The commission disagrees that the adopted amendments add further criteria to the application process for commission approved doctors or designated doctors. The purpose of the adopted amendments is to expedite commission actions to either delete a doctor from the commission's Approved Doctor List (ADL), or deny a doctor admission to the commission's Approved Doctor List (ADL) and/or Designated Doctor List (DDL), when the doctor's license has been revoked, suspended, or has not been renewed by the appropriate licensing or certification authority. Specifically, the amendments shorten a doctor's time to respond to commission notices of intended action in appropriate circumstances. The recommendations made by commenter regarding incentive based programs and adjuster abuses are not related to, or within the scope of, the adopted rule amendments. The commission notes, however, that the Legislature statutorily provided for the grant mentioned by the commenter at Texas Labor Code §402.062(b). The commission has met all requirements imposed by the Legislature regarding the grant.

The rule amendments are adopted pursuant to the Texas Labor Code, §401.011 which contains definitions used in the Texas Workers' Compensation Act; the Texas Labor Code §401.024, which provides the Commission the authority to require use of facsimile or other electronic means to transmit information in the system; the Texas Labor Code §402.042, which authorizes the Executive Director to enter orders as authorized by the Act as well as to prescribe the form and manner and procedure for transmission of information to the Commission; the Texas Labor Code §402.061, which authorizes the Commission to adopt rules necessary to administer the Act; the Texas Labor Code §406.010, which authorizes the Commission to adopt rules regarding claims service; the Texas Labor Code §408.021, which states an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed; the Texas Labor Code §408.022, which address choice of treating doctor; the Texas Labor Code §408.023, which requires the Commission to develop a list of approved doctors and lay out the requirements for being on the list and which grants the Commission the authority to provide for exceptions to the requirement to be on the ADL, as necessary to ensure that employees have access to health care; the Texas Labor Code §408.0231, which provides the Commission with the responsibility for maintenance of the list, with the authority for imposing sanctions, and requires the Commission to adopt rules; the Texas Labor Code §408.025 which requires the Commission to specify by rule what reports a health care provider is required to file; the Texas Labor Code §413.002, which requires the Commission to monitor health care providers and carriers to ensure compliance with Commission rules relating to health care including medical policies and fee guidelines; the Texas Labor Code §413.011, which requires the Commission by rule to establish medical policies relating to necessary treatments for injuries and designed to ensure the quality of medical care and to achieve effective medical cost control; the Texas Labor Code §413.012, which requires the Commission to review and revise medical policies and fee guidelines at least every two years to reflect current medical treatment and fees that are reasonable and necessary; the Texas Labor Code §413.013, which requires the Commission by rule to establish a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services; a program for the systematic monitoring of the necessity of the treatments administered and fees charged and paid for medical treatments or services including the authorization of prospective, concurrent or retrospective review and a program to detect practices and patterns by insurance carriers in unreasonably denying authorization of payment for medical services, and a program to increase the intensity of review; the Texas Labor Code §413.014, which requires the Commission to specify by rule, except for treatments and services required to treat a medical emergency, which health care treatments and services require express preauthorization and concurrent review by the carrier as well as allowing health care providers to request pre-certification and allowing the carriers to enter agreements to pay for treatments and services that

do not require preauthorization or concurrent review. This mandate also states the carrier is not liable for the cost of the specified treatments and services unless preauthorization is sought by the claimant or health care provider and either obtained or ordered by the Commission; the Texas Labor Code §413.017, which establishes medical services to be presumed reasonable when provided subject to prospective, concurrent review and are authorized by the carrier; the Texas Labor Code §413.031, which establishes the right to access medical dispute resolution; the Texas Labor Code §413.041, which requires financial disclosure of financial interests by health care providers and their employers, which requires the Commission to adopt federal standards prohibiting payment of acceptance of payment in exchange for health care referrals, and which prohibits payment to a provider during a period of noncompliance with disclosure requirements; the Texas Labor Code §413.0511, which creates the position of Medical Advisor and imbues the position with certain responsibilities and authority; the Texas Labor Code §413.0512, which creates the Medical Quality Review Panel (MQRP) and grants it certain responsibilities and authority; certain responsibilities and authority; the Texas Labor Code §413.0513, which lays out confidentiality provisions relating to the MQRP; the Texas Labor Code §414.007, which allows the review of referrals from the Medical Review Division by the Division of Compliance and Practices; and; the Texas Labor Code §415.0035, which establishes administrative violations for repeated administrative violations.

§180.20. Commission Approved Doctor List.

(a) This section governs the commission's approved doctor list (ADL). Except in an emergency, as defined in §133.1 of this title (relating to Definitions For Chapter 133) or for the immediate post-injury medical care, as defined in §180.1 of this title (relating to Definitions) injured employees (employees) shall receive health care from a doctor on the ADL:

(1) The ADL established by the statute and commission rules as it exists on August 31, 2003 is null and void as of September 1, 2003. Any doctor on the ADL prior to September 1, 2003 who does not reapply to be on the ADL or whose application is not approved will not be on the ADL as of September 1, 2003.

(2) On or after September 1, 2003, doctors who provide any functions in the Texas workers' compensation system are required to be on the ADL.

(b) Until September 1, 2003, unless deleted from the list by the commission, the ADL includes all doctors licensed in Texas on or after January 1, 1993, and doctors licensed in other jurisdictions who have been added to the list by the commission. Doctors licensed in other jurisdictions may ask to be added to the list by submitting a written request containing information prescribed by the commission. Doctors on the ADL on or after September 1, 2003, whether licensed in Texas or licensed by another jurisdiction, shall have:

(1) successfully completed the training required by §180.23(h) of this title (relating to Commission Required Training for Doctors/Certificate of Registration Levels);

(2) applied for a Certificate of Registration with the commission in the form and manner prescribed by the commission; and

(3) disclosed financial interests as required by Texas Labor Code §413.041 and §180.24 of this title (relating to Financial Disclosure) with the application.

(c) An incomplete application for registration to be admitted to the ADL pursuant to this section shall be rejected and shall not be processed. A complete application shall include:

(1) general contact information including, but not limited to: name, mailing address, voice and facsimile numbers, and an email address;

(2) the training module taken and date completed;

(3) Impairment Rating Skills Examination score, if applicable;

(4) verification of licensure;

(5) disciplinary actions or practice restrictions by an appropriate licensing or certification authority, if any;

(6) an agreement that the doctor will comply with the Statute and Rules, including but not limited to, cooperating with commission monitoring and review efforts such as audits by the commission and paying audit bills when required by Statute or Rule;

(7) if the doctor applying for the ADL is not licensed in this state but wishes to perform utilization review and/or peer reviews for an insurance carrier or its agent, the applicant must certify that the reviews will be performed under the direction of a doctor who is licensed in this state and has an ADL Level 2 Certificate of Registration (as provided in §180.23 of this title). The carrier requesting such a review must ensure that the work was performed under the direction of an appropriate in-state doctor, and, upon request, must identify the in-state doctor and present documentation that the review was performed under the direction of that doctor; and

(8) if the doctor is applying for a Level 1 Certificate of Registration with a Non-Medical Management designation as provided in §180.23(c)(1)(D) of this title, the doctor must indicate in the appropriate place on the application that the doctor's practice does not include ongoing medical management, including pain management, of injured employees.

(d) The commission may utilize members of the Medical Quality Review Panel for evaluating ADL applications and making recommendations to the Medical Advisor to approve, approve with condition(s) or restriction(s), or deny admission to the ADL.

(e) The commission may grant a temporary exception to the requirement to be on the ADL to ensure that employees have access to health care pending commission action on a doctor's application. A doctor with a temporary exception must meet all the requirements that doctors on the ADL must meet. A temporary exception does not constitute "being on the ADL," "approval to be on the ADL," or "denial of an application to be on the ADL."

(f) Doctors shall be denied admission to the ADL or admitted with condition(s) or restriction(s) for:

(1) failing to complete required training;

(2) having relevant restriction(s) on their practice (including, but not limited to, prior deletion from the ADL); or

(3) other activities which warrant application denial or restriction such as grounds that would require or allow the Medical Advisor to recommend deletion of a doctor from the ADL or other sanction of a doctor as specified in §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or the Statute and Rules.

(g) The commission shall notify a doctor of the commission's approval, approval with condition(s) or restriction(s), or denial of the doctor's application to the ADL.

(1) Denials or approvals with condition(s) or restriction(s) shall include the reason(s) for the action.

(2) Within 15 days after receiving the notice, the doctor may file a response which addresses the reason(s) given for the denial or admission with condition(s) or restriction(s).

(A) If a response is not received by the 15th day after the date the doctor received the notice, the action shall be final effective the following day. No further notice shall be sent.

(B) If a response which disagrees with the action is timely received, the commission shall review the response and shall notify the doctor of the commission's final decision. If the final decision is not an unrestricted approval, the commission's final notice shall provide the reason(s) why the doctor's response did not convince the commission to grant the doctor an unrestricted admission to the ADL. The denial or admission with condition(s) or restriction(s) shall be effective the day following the date the doctor receives notice of the final decision unless otherwise specified in the notice.

(3) Notwithstanding other provisions of this subsection, for denials pursuant to §180.20(f)(1) of this title (relating to Commission Approved Doctor List), and for denials pursuant to §180.20(f)(3) of this title wherein the subsection of §180.26 of this title relied upon is subsection (b), and within five working days (as defined by §102.3(b) of this title (relating to Computation of Time)) after receiving the notice, the doctor may file a response which addresses the reason(s) given for the denial.

(A) If a response is not received by the fifth working day after the date the doctor received the notice, the action shall be final effective the following day. No further notice shall be sent.

(B) If a response which disagrees with the action is timely received, the commission shall review the response and shall notify the doctor of the commission's final decision. A final decision denying the doctor admission to the ADL shall provide the reason(s) why the doctor's response did not convince the commission to grant the doctor admission to the ADL. The denial shall be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(4) All notices under this subsection shall be delivered by a verifiable means. Date of receipt for notices shall be determined in accordance with §102.5(d) of this title (relating to General Rules for Written Communication to and from the Commission).

(5) The fact that the commission did not take action to deny admission to a doctor or admit a doctor with condition(s) or restriction(s) to the ADL does not waive the commission's right to review or further review a doctor and take action at a later date.

(h) Chapter 133 of this title (relating to Benefits - Medical Benefits) applies to all medical bills, including those from doctors who were not on the ADL at the time the health care was rendered.

(1) All licensed doctors, whether on the ADL or not, are entitled to reimbursement in accordance with the Statute and Rules for providing reasonable and necessary emergency or immediate post-injury medical care.

(2) A doctor is entitled to reimbursement in accordance with the doctor's level of Certificate of Registration and the Statute and Rules for directly or indirectly providing reasonable and necessary health care (other than emergency or immediate post-injury medical care) or other medical services (such as peer reviews or other evaluations) if:

(A) the doctor was on the ADL at the time the service was provided;

(B) the doctor was granted a temporary exception to the requirement to be on the ADL at the time the service was provided; or

(C) the doctor has been granted an exception on a case-by-case basis as provided in §180.23(b) of this title, and the claim for which the doctor is billing is one for which the doctor has been granted an exception.

(3) A doctor who is entitled to reimbursement based on paragraph (2)(A) and (B) of this subsection may perform medical services and bill for those services only after notification of such entitlement from the commission.

(4) A carrier who receives a bill from a doctor who is not entitled to reimbursement pursuant to paragraph (2) of this subsection shall deny the medical bill and send the required explanation of benefits (EOB) with the appropriate payment exception code.

(5) Notwithstanding this subsection, a doctor's entitlement to direct or indirect reimbursement for health care or medical opinions directly or indirectly provided (other than for emergency or immediate post-injury medical care) may be limited by sanction imposed by the commission.

(i) The commission shall make available through its Internet website the names, licensure and other identification information, and ADL or ADL exception status of:

(1) doctors who are not on the ADL because their applications were denied;

(2) doctors on the ADL (including a description of any privileges, conditions or restrictions placed on the doctor by the commission);

(3) doctors deleted or suspended from the ADL or otherwise sanctioned by the commission (including a description of the sanction);

(4) doctors reinstated to the ADL or whose sanctions were lifted by the commission; and

(5) doctors granted a temporary exception from the requirement to be on the ADL pursuant to subsection (e) of this section or on a case-by-case basis.

(j) Doctors who are on the ADL or who have applied to be on the ADL shall provide the commission with updated information within 30 days of a change in any of the information provided to the commission on the doctor's ADL application.

(k) Level 1 Certificates of Registration are valid for two years from date of issuance, and Level 2 Certificates of Registration are valid for four years from date of issuance unless the Certificate provides otherwise, the date is revised by agreed settlement pursuant to §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or Texas Government Code §2001.056 (relating to Informal Disposition of Contested Case), Commission order or decision, or the doctor has been removed from the ADL. Upon expiration of a doctor's Certificate of Registration, the doctor must reapply for the ADL.

§180.21. Commission Designated Doctor List.

(a) In order to serve as a designated doctor, a doctor must be on the Designated Doctor List (DDL).

(b) To be on the DDL prior to September 1, 2003, the doctor shall at a minimum:

(1) be currently active on the Approved Doctor List (ADL) as set forth in Texas Labor Code §408.023 and §180.20 of this title (relating to Commission Approved Doctor List);

(2) have maintained for the past three years and continue to maintain an active practice;

(3) have filed a request to be on the DDL in the form and manner prescribed by the commission and been approved by the commission; and

(4) meet the following training requirements:

(A) have successfully completed commission-approved training in the proper use of the AMA Guides prior to submission of an application;

(B) have successfully completed commission-approved training at least every two years from the date of the last training; and

(C) have passed the commission-approved written examination for impairment rating training within the timeframe specified by the commission.

(c) To be on the DDL on or after September 1, 2003, the doctor shall at a minimum:

(1) be currently active on the ADL with a Level 2 Certificate of Registration with no condition(s) or restriction(s), or have a temporary exception to the requirement to be on the ADL, as set forth in Texas Labor Code §408.023 and §180.20 of this title;

(2) have had an active practice for one year during their career;

(3) be fully authorized to assign impairment ratings and certify maximum medical improvement (MMI) under §180.23(i) of this title (relating to Commission Required Training for Doctors/Certificate of Registration Levels);

(4) have filed a request in the form and manner prescribed by the commission, and have been approved by the commission to be included on the DDL; and

(5) either maintain an active practice or successfully complete commission-approved supplemental training on medical issues relevant to workers' compensation and/or serving as a designated doctor. Supplemental training shall be completed between 18 and 30 months following the doctor's passing the test required to obtain and retain full MMI/impairment authorization.

(d) An incomplete application for registration to be admitted to the DDL pursuant to this section and other Rules shall be rejected and shall not be processed. A complete application shall include:

(1) general contact information including, but not limited to: name, mailing address, voice and facsimile numbers and an email address;

(2) the training certificate indicating the level of training completed;

(3) Impairment Rating Skills Examination score;

(4) verification of licensure;

(5) information on the doctor's training and experience in various types of health care and injury areas; and

(6) disciplinary actions or practice restrictions by an appropriate licensing or certification authority, if any.

(e) The commission may utilize members of the Medical Quality Review Panel (MQRP) for evaluating DDL applications and making recommendations to the Medical Advisor to approve or deny admission to the DDL. The commission may also utilize members of the MQRP regarding deletion, suspension, or other sanction of a designated doctor as provided in this section.

(f) Doctors shall be denied admission to the DDL:

(1) if the doctor does not meet the requirements of subsection (c)(1) of this section;

(2) if the doctor has not completed required training in accordance with §180.23(i) of this title and passed the commission approved test;

(3) for failing to submit a complete application in accordance with this section;

(4) for having a relevant restriction on their practice (including, but not limited to, prior deletion from the ADL or DDL or a prior ADL restriction); or

(5) for other activities which warrant application denial such as grounds that would require the Medical Advisor to recommend deletion of a doctor from the ADL or other sanction of a doctor as specified in §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or the Statute and Rules.

(g) The commission shall notify a doctor of the commission's approval or denial of the doctor's application to the DDL.

(1) Denials shall include the reason(s) for the denial.

(2) Within 15 days after receiving the notice, the doctor may file a response which addresses the reasons given for the denial.

(A) If a response is not received by the 15th day after the date the doctor received the notice, the denial shall be final effective the following day. No further notice shall be sent.

(B) If a response which disagrees with the denial is timely received, the commission shall review the response and shall notify the doctor of the commission's final decision. If the final decision is a denial, the commission's final notice shall provide the reason(s) why the doctor's response did not convince the commission to admit the doctor to the DDL. The denial shall be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(3) Notwithstanding other provisions of this subsection, for denials pursuant to §§180.21(f)(1)-(3) of this title (relating to Commission Designated Doctor List), and for denials pursuant to §180.21(f)(5) of this title wherein the subsection of §180.26 of this title relied upon is subsection (b), and within five working days (as defined by §102.3(b) of this title (relating to Computation of Time)) after receiving the notice, the doctor may file a response which addresses the reason(s) given for the denial.

(A) If a response is not received by the fifth working day after the date the doctor received the notice, the action shall be final effective the following day. No further notice shall be sent.

(B) If a response which disagrees with the action is timely received, the commission shall review the response and shall notify the doctor of the commission's final decision. A final decision denying the doctor admission to the DDL shall provide the reason(s) why the doctor's response did not convince the commission to grant the doctor admission to the DDL. The denial shall be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(4) All notices under this subsection shall be delivered by a verifiable means. Date of receipt for notices shall be determined in accordance with §102.5(d) of this title (relating to General Rules for Written Communication to and from the Commission).

(5) The fact that the commission did not take action to deny or restrict admission to the DDL does not waive the commission's right to review or further review a doctor and take action at a later date.

(h) When necessary because the injured employee is temporarily located or is residing out-of-state, the commission may waive any of the requirements as specified in this rule for an out-of-state doctor to serve as a designated doctor to facilitate a timely resolution of the dispute.

(i) Doctors on the DDL shall provide the commission with updated information within 30 days of a change in any of the information provided to the commission on the doctor's DDL application.

(j) In addition to the grounds for deletion or suspension from the ADL or for issuing other sanctions against a doctor under §180.26 of this title, the commission shall delete or suspend a doctor from the DDL, or otherwise sanction a designated doctor for noncompliance with requirements of this section or any of the following:

(1) four refusals within a 90-day period, or four consecutive refusals to perform within the required time frames, a commission requested appointment for which the doctor is qualified;

(2) misrepresentation or omission of pertinent facts in medical evaluation and narrative reports;

(3) having a pattern of practice of unnecessary referrals to other health care providers for the assignment of an impairment rating or determination of MMI;

(4) submission of inaccurate or inappropriate reports as a pattern of practice due to insufficient examination and analysis of medical records;

(5) willful failure to timely respond to a request for clarification from the commission regarding an examination or failure to timely respond as a pattern of practice;

(6) assignments of MMI and/or impairment ratings overturned in a contested case hearing, appeals panel decision and/or court decision;

(7) any of the factors listed in subsection (f) of this section that would allow for denial of admission to the DDL;

(8) failure to timely successfully complete training and testing requirements as specified in subsections (b) or (c) of this section;

(9) failure to notify the commission field office of any disqualifying association within 48 hours of receiving notice of being selected as a designated doctor as a pattern of practice or conducting an examination when there is a disqualifying association;

(10) failure to maintain an active practice or failure to maintain the alternate training requirements outlined in subsection (c)(5) of this section;

(11) self-referring for treatment or becoming the employee's treating doctor for the medical condition evaluated by the designated doctor; or

(12) other significant violation of Statute and/or Rules while serving as a designated doctor.

(k) The process for notification and opportunity for appeal of a sanction is governed by §180.27 of this title (relating to Sanctions Process/Appeals) except that suspension, deletion, or other sanction relating to the DDL shall be in effect during the pendency of any appeal.

(l) The commission shall make available through its Internet website the names of:

(1) doctors on the DDL;

(2) doctors deleted or suspended from the list or otherwise sanctioned by the commission (including a description of the sanction); and

(3) doctors reinstated to the list or whose sanctions were lifted by the commission.

(m) When a doctor is added to the DDL or readmitted following a suspension or deletion, the doctor shall be placed at the bottom of the list for rotation purposes under Texas Labor Code §408.0041.

(n) The following definitions apply to this section:

(1) Active practice--a doctor has an active practice if the doctor maintains routine office hours of at least 20 hours per week for the treatment of patients.

(2) Disqualifying Association--any association which may reasonably be perceived as having potential to influence the conduct or decision of the designated doctor.

(A) A disqualifying association between a designated doctor and a party may include:

(i) receipt of income, compensation, or payment of any kind not related to health care provided by the doctor;

(ii) shared investment or ownership interest;

(iii) contracts or agreements that provide incentives, such as referral fees, payments based on volume or value, and waiver of beneficiary coinsurance and deductible amounts;

(iv) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other services related to the management of the doctor's practice;

(v) personal or family relationships; or

(vi) any other financial arrangement that would require disclosure under §180.24 of this title (relating to Financial Disclosure).

(B) Receipt of normal payments rendered for services provided pursuant to managed care/preferred provider contracts, or any payment in accordance with the Texas Workers' Compensation Act and rules, is not a disqualifying association.

(3) Party--any of the following entities including any of their agents or representatives: the insurance carrier, health care provider (including designated doctor and treating doctor), injured employee, or employer.

(4) Self-Refer--treatment by the designated doctor or referral for treatment to another health care provider with which the designated doctor has a disqualifying association.

§180.27. Sanctions Process/Appeals/Restoration/Reinstatement.

(a) If the commission intends to take action under §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or action against a designated doctor under §180.21 of this title (relating to Commission Designated Doctor List), other than in the case where a progressive disciplinary agreement under §180.26(e) of this title was entered into, the commission shall notify the person ("person" also includes a carrier) to be sanctioned by verifiable means of the commission's intent.

(1) Not later than 20 days after receiving the notice, a doctor may request a hearing at the State Office of Administrative Hearings

by filing such a request with the Chief Clerk of Proceedings at the commission.

(2) If no request for hearing is filed within the time allowed, the recommendation for sanction will be reviewed by the commissioners at a public meeting and a decision made. If a hearing was held, the commissioners shall review the decision of the administrative law judge (ALJ) after the hearing is held.

(b) If the commission modifies, amends, or changes a recommended finding of fact or conclusion of law, or order of the ALJ, the commission's final order shall state the legal basis and the specific reasons for the change.

(c) If the commissioners vote to impose the sanction, the commission shall notify the person by issuing an order of which describes the effects of the sanction. This order shall be delivered by verifiable means with a copy to the appropriate licensing or certification authority and, if the sanction is against a doctor, copies shall be delivered to those injured employees the commission is aware are being treated by that doctor.

(d) Failure to comply with the sanction may result in further sanctioning by the commission.

(e) A person who was sanctioned can apply to have the sanction lifted (whether through restoration of privileges or re-certification) by applying in the form and manner prescribed by the commission.

(1) The request shall be evaluated by the Medical Advisor and /or members of the Medical Quality Review Panel. The requestor shall be liable for the cost of the review, which may include an audit of the records of the requestor.

(A) If, in the Medical Advisor's opinion, the person has all the appropriate unrestricted licenses/certifications, has overcome the conditions that resulted in sanction, and should be reinstated, the Medical Advisor shall recommend that the commissioners reinstate the doctor or restore the privileges removed or restricted by the sanction.

(B) If, in the Medical Advisor's opinion, the person has not met the requirements for reinstatement or restoration of privileges, the commission shall notify the person by verifiable means of the intent to recommend to the commissioners that the sanctions not be lifted. Within 15 days after receiving the notice, a doctor may file a response that addresses the reasons given that the recommendation was to be made. The Medical Advisor shall review the response and make a final recommendation to the commissioners. A copy of the requestor's response to the commission shall be provided to the commissioners for consideration.

(2) The commissioners shall consider the matter in a public meeting and shall notify the requestor by verifiable means with a copy to the appropriate licensing or certification authority. If the commissioners choose to not lift the sanction, the commissioners may include in their final decision the conditions that the sanctioned person must meet before the commission will reconsider lifting the sanctions including, but not limited to, the amount of time that the person must wait prior to rerequesting lifting the sanction.

(f) Notwithstanding any other provision of this section, deletion from the Approved Doctor List by the Executive Director pursuant to §180.26(b) of this title shall be governed by this subsection.

(1) Prior to deletion, the Executive Director or designee shall notify a doctor of the intention to delete the doctor and the grounds for that action.

(2) Within five working days (as defined by §102.3(b) of this title (relating to Computation of Time)) after receiving the notice of intent, a doctor may file a response to the reasons given as grounds for the deletion with the Executive Director or designee.

(A) If a response is not received by the fifth working day after the date the doctor received the notice of intent, the doctor shall be deleted effective the following day. No subsequent notice shall be sent.

(B) If the response is agreement, the doctor shall be deleted effective on the earlier of the date the doctor agrees to the deletion or the day following the fifth working day after the date the doctor received the notice of intent. No subsequent notice shall be sent.

(C) If a response which disagrees with the grounds for deletion is timely received and after reviewing the response, the Executive Director or designee determines:

(i) that the grounds do not exist for deletion under §180.26(b) of this title, the doctor shall be notified that he was not deleted; or

(ii) that the grounds for deletion do exist under §180.26(b) of this title, the doctor shall be deleted effective the day following the date the doctor receives notice of the deletion unless otherwise specified in the notice.

(3) All notices under this subsection shall be delivered by a verifiable means. Date of receipt for notices shall be determined in accordance with §102.5(d) of this title (relating to General Rules for Written Communication to and from the Commission).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 23, 2004.

TRD-200405324
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Effective date: September 12, 2004
Proposal publication date: April 30, 2004
For further information, please call: (512) 804-4287

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 377. HYDROGRAPHIC SURVEY PROGRAM

31 TAC §377.3

The Texas Water Development Board (board) adopts an amendment to 31 TAC §377.3 relating to the Hydrographic Survey Program without changes to the proposed text as published in the July 2, 2004 issue of the *Texas Register* (29 TexReg 6227) and will not be republished. The amendment to §377.3(a) revises the authority of the executive administrator to execute contracts to conduct hydrographic surveys to include the authority to execute contracts with any entity.

The amendment to §377.3(a) inserts the language "with any person" to reflect that the executive administrator may execute a contract for a hydrographic survey with any person rather than just the political subdivisions and agencies listed in the existing subsection. The board has encountered instances in which a hydrographic survey is requested for a reservoir that serves as the water supply of a political subdivision of this state but is actually owned by a water supply corporation or other private entity. While the survey will benefit the political subdivision as well as the state, the contract should be executed with the entity that owns or operates the lake. This amendment would provide that authority to the executive administrator. The remaining portion of the section is rearranged to retain the statutory requirements that a survey be performed upon the request of a political subdivision or agency of this state, a neighboring state, or a federal agency, and if the information collected will benefit this state. These requirements are imposed as a condition for the executive administrator to execute a contract to perform the survey in order to insure compliance with the statute.

There were no comments received on the proposed amendment.

Statutory authority: Water Code, §15.805.

Cross-reference to statute: Water Code, Chapter 15, Subchapter M.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 17, 2004.

TRD-200405198
Suzanne Schwartz
General Counsel
Texas Water Development Board
Effective date: September 6, 2004
Proposal publication date: July 2, 2004
For further information, please call: (512) 475-2052

TEXAS DEPARTMENT OF INSURANCE

Notification Pursuant to the Insurance Code, Chapter 5, Subchapter L

As required by the Insurance Code, Article 5.96 and 5.97, the ***Texas Register*** publishes notice of proposed actions by the Texas Department of Insurance. Notice of action proposed under Article 5.96 must be published in the ***Texas Register*** not later than the 30th day before the proposal is adopted. Notice of action proposed under Article 5.97 must be published in the ***Texas Register*** not later than the 10th day before the proposal is adopted. The Administrative Procedure Act, Government Code, Chapters 2001 and 2002, does not apply to department action under Articles 5.96 and 5.97.

The complete text of the proposal summarized here may be examined in the offices of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas 78701.

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts it from the requirements of the Administrative Procedure Act.

Texas Department of Insurance

Proposed Action on Rules

EXEMPT FILING NOTIFICATION PURSUANT TO THE INSURANCE CODE CHAPTER 5, SUBCHAPTER L, ARTICLE 5.96

The Commissioner of Insurance (Commissioner) will hold a public hearing under Docket No. 2597 on October 7, 2004, at 9:30 o'clock a.m., in Room 100 of the William P. Hobby Building, 333 Guadalupe Street in Austin, Texas to consider a petition by the staff of the Texas Department of Insurance (TDI) proposing the adoption of revised Texas Workers' Compensation Classification Relativities (classification relativities) to replace those adopted in Commissioner's Order No. 02-1122 dated October 28, 2002; and the adoption of a revised table to amend the Texas Basic Manual of Rules, Classification, and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance (Basic Manual) concerning the Expected Loss Rates and Discount Ratios used in experience rating. Staff's petition (Ref. No. W-0804-14-I) was filed on August 25, 2004.

In its petition, the staff requests consideration of a schedule of revised classification relativities and tables amending the Basic Manual. The revised classification relativities schedule is proposed to replace the classification relativities schedule adopted in Commissioner's Order No. 02-1122 dated October 28, 2002. The tables amending the Basic Manual concern the Expected Loss Rates and Discount Ratios.

The staff requests that the proposed revised classification relativities be available for adoption by insurers immediately, but that their use be mandatory for all policies with an effective date on or after January 1, 2005 unless the insurer makes an independent filing to justify insurer specific classification relativities. The staff further requests that the revised tables amending the Basic Manual be made effective for workers' compensation experience modifiers with an effective date on or after January 1, 2005.

Article 5.60(a) of the Texas Insurance Code authorizes the Commissioner to determine hazards by classes and fix classification relativities applicable to the payroll in each class for workers' compensation insurance. Article 5.60(b) requires TDI to adopt a uniform experience rating plan. Article 5.60(d) provides that the Commissioner revise the classification system and rating plans at least once every five years.

The classification relativities currently in effect were based on experience data reflecting workers' compensation experience from policies with effective dates in 1995 through 1999. The proposed classification relativities are based on the analysis of experience data from policies with effective dates in 1997 through 2001. The staff's proposed classification relativities reflect changes in experience that occur over time, due to such things as technological advances and improvements in safety programs.

Current classification relativities are 70% of the 1994 classification relativities. This level of classification relativities was adopted in Commissioner's Order No. 98-0998 dated August 27, 1998 to more accurately reflect changes in experience and changes that occurred with the passage of time due to such things as technological advances and improvement in safety programs. In addition, this level of classification relativities produced numbers that were more in line with what was actually being charged at the time.

Recent projections of Texas loss experience show lower combined ratios, on average, for workers compensation insurers. Therefore, staff proposes that all of the revised classification relativities be multiplied by a factor of 65/70, bringing the relativities to 65% of the 1994 relativities.

Modifications to the classification relativities require concurrent changes in the Table II of the Basic Manual concerning the Expected Loss Rates and Discount Ratios. The current Table II, which became effective on January 1, 2003, contains expected loss rates that were based on the level of losses used to experience rate the average policy that would be subject to the new expected loss rates. Such a policy would be effective on July 1, 2003 and would reflect the current classification relativities. Staff proposes an adjustment to make the expected loss rates more reflective of the level of losses that would be used to experience rate policies that would be effective in 2005, and reflect the proposed classification relativities. Staff also proposes to cap changes in the expected loss rates to +25% and -25%.

Copies of the full text of the staff petition and the proposed revised schedule and table are available for review in the Office of the Chief Clerk of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas 78714-9104. For further information or to request copies of the petition and proposed revised schedule and table, please contact Sylvia Gutierrez at (512) 463-6327 (refer to Ref. No. W-0804-14-I).

Comments on the proposed changes may be submitted in writing within 30 days after publication of the proposal in the *Texas Register* to the Office of Chief Clerk, P.O. Box 149104, MC 113-2A, Austin, Texas 78714-9104. An additional copy of the comment should be submitted simultaneously to Philip O. Presley, Chief Property and Casualty Actuary, P.O. Box 149104, MC 105-5F, Austin, Texas 78714-9104.

This notification is made pursuant to the Texas Insurance Code, Article 5.96, which exempts action taken under this article from the requirements of the Administrative Procedure Act (Government Code, Title 10, Chapter 2001).

TRD-200405374
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: August 25, 2004

♦ ♦ ♦

Final Action on Rules

Effective Date: November 2, 2004

EXEMPT FILING NOTIFICATION PURSUANT TO THE INSURANCE CODE CHAPTER 5, SUBCHAPTER L, ARTICLE 5.96 ADOPTION OF NEW AND/OR ADJUSTED 2004 AND 2005 MODEL PRIVATE PASSENGER AUTOMOBILE PHYSICAL DAMAGE RATING SYMBOLS FOR THE TEXAS AUTOMOBILE RULES AND RATING MANUAL

The Commissioner of Insurance adopts amendments proposed by Staff to the Texas Automobile Rules and Rating Manual (the Manual). The amendments consist of new and/or adjusted 2004 and 2005 model Private Passenger Automobile Physical Damage Rating Symbols and revised identification information. Staff's petition (Ref. No. A-0704-09-I) was published in the July 16, 2004, issue of the *Texas Register* (29 TexReg 6971).

The new and/or adjusted symbols for the Manual's Symbols and Identification Section reflect data compiled on damageability, repairability, and other relevant loss factors for the 2004 and 2005 model year of the listed vehicles.

The amendments as adopted by the Commissioner of Insurance are shown in exhibits on file with the Chief Clerk under Ref. No. A-0704-09-I, which are incorporated by reference into Commissioner's Order No. 04-0807.

The Commissioner of Insurance has jurisdiction over this matter pursuant to Insurance Code Articles 5.10, 5.96, 5.98, and 5.101.

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that the Manual is amended as described herein, and the amendments are adopted to become effective on the 60th day after publication of the notification of the Commissioner's action in the *Texas Register*.

TRD-200405262
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: August 20, 2004

♦ ♦ ♦

Effective Date: November 2, 2004

EXEMPT FILING NOTIFICATION PURSUANT TO THE INSURANCE CODE CHAPTER 5, SUBCHAPTER L, ARTICLE 5.96

ADOPTION OF NEW AND/OR ADJUSTED 2002 AND 2003 MODEL PRIVATE PASSENGER AUTOMOBILE PHYSICAL DAMAGE RATING SYMBOLS FOR THE TEXAS AUTOMOBILE RULES AND RATING MANUAL

The Commissioner of Insurance adopts amendments proposed by Staff to the Texas Automobile Rules and Rating Manual (the Manual). The amendments consist of new and/or adjusted 2002 and 2003 model Private Passenger Automobile Physical Damage Rating Symbols and revised identification information. Staff's petition (Ref. No. A-0704-10-I) was published in the July 23, 2004, issue of the *Texas Register* (29 TexReg 7151).

The new and/or adjusted symbols for the Manual's Symbols and Identification Section reflect data compiled on damageability, repairability, and other relevant loss factors for the 2002 and 2003 model year of the listed vehicles.

The amendments as adopted by the Commissioner of Insurance are shown in exhibits on file with the Chief Clerk under Ref. No. A-0704-10-I, which are incorporated by reference into Commissioner's Order No. 04-0812.

The Commissioner of Insurance has jurisdiction over this matter pursuant to Insurance Code Articles 5.10, 5.96, 5.98, and 5.101.

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that the Manual is amended as described herein, and the amendments are adopted to become effective on the 60th day after publication of the notification of the Commissioner's action in the *Texas Register*.

TRD-200405373
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: August 25, 2004

♦ ♦ ♦

REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Proposed Rule Reviews

Texas Animal Health Commission

Title 4, Part 2

The Texas Animal Health Commission (commission), will review and consider for readoption, revision, or repeal of Chapter 36, concerning "Exotic Livestock and Fowl", in accordance with the Texas Government Code, Section 2001.039. The rules to be reviewed are found in Chapter 36, which is located in Title 4, Part 2, of the Texas Administrative Code and contain the following sections: §36.1, Definitions; and §36.2, General.

The commission finds reason for the rules to continue to exist but will consider comments related to whether reasons for re-adoption of these rules continue to exist, whether amendments or changes are needed, or whether repeal of the chapter is appropriate. Any changes to the rules will be proposed by the commission after reviewing the rules and considering the comments received in response to this notice. Any proposed rule changes will then appear in the "Proposed Rules" section of the *Texas Register* and will be adopted in accordance with the requirements of the Administrative Procedure Act, Texas Government Code Annotated, Chapter 2001.

The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments or questions regarding this notice of intention to review may be submitted in writing, within 30 days following the publication of this notice in the *Texas Register*, to Delores Holubec, P.O. Box 12966, Austin, Texas 78711-2966. They may also be sent by facsimile to (512) 719-0721 or by e-mail to comments@tahc.state.tx.us. Comments will be reviewed and discussed in a future commission meeting.

TRD-200405353
Gene Snelson
General Counsel
Texas Animal Health Commission
Filed: August 24, 2004

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The Texas Animal Health Commission (commission), will review and consider for readoption, revision, or repeal of Chapter 40, concerning "Chronic Wasting Disease", in accordance with the Texas Government Code, Section 2001.039. The rules to be reviewed are found in Chapter 40, which is located in Title 4, Part 2, of the Texas Administrative Code and contain the following sections: §40.1, Definitions; §40.2, General Requirements; §40.3, Herd Status Plans for Cervidae; and §40.4, Entry Requirements.

The commission finds reason for the rule to continue to exist but will consider comments related to whether reasons for re-adoption of these rules continue to exist, whether amendments or changes are needed, or whether repeal of the chapter is appropriate. Any changes to the rules will be proposed by the commission after reviewing the rules and considering the comments received in response to this notice. Any proposed rule changes will then appear in the "Proposed Rules" section of the *Texas Register* and will be adopted in accordance with the requirements of the Administrative Procedure Act, Texas Government Code Annotated, Chapter 2001.

The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments or questions regarding this notice of intention to review may be submitted in writing, within 30 days following the publication of this notice in the *Texas Register*, to Delores Holubec, P.O. Box 12966, Austin, Texas 78711-2966. They may also be sent by facsimile to (512) 719-0721 or by e-mail to comments@tahc.state.tx.us. Comments will be reviewed and discussed in a future commission meeting.

TRD-200405354
Gene Snelson
General Counsel
Texas Animal Health Commission
Filed: August 24, 2004

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The Texas Animal Health Commission (commission), will review and consider for readoption, revision, or repeal of Chapter 45, concerning "Reportable Disease", in accordance with the Texas Government Code, Section 2001.039. The rules to be reviewed are found in Chapter 45, which is located in Title 4, Part 2, of the Texas Administrative Code and contain the following sections: §45.1, Definitions; and §45.2, Duty to Report.

The commission finds reason for the rule to continue to exist but will consider comments related to whether reasons for re-adoption of these rules continue to exist, whether amendments or changes are needed, or whether repeal of the chapter is appropriate. Any changes to the rules will be proposed by the commission after reviewing the rules and considering the comments received in response to this notice. Any proposed rule changes will then appear in the "Proposed Rules" section of the *Texas Register* and will be adopted in accordance with the requirements of the Administrative Procedure Act, Texas Government Code Annotated, Chapter 2001.

The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments or questions regarding this notice of intention to review may be submitted in writing,

within 30 days following the publication of this notice in the *Texas Register*, to Delores Holubec, P.O. Box 12966, Austin, Texas 78711-2966. They may also be sent by facsimile to (512) 719-0721 or by e-mail to comments@tahc.state.tx.us. Comments will be reviewed and discussed in a future commission meeting.

TRD-200405355
Gene Snelson
General Counsel
Texas Animal Health Commission
Filed: August 24, 2004

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Texas State Board of Medical Examiners

Title 22, Part 9

The Texas State Board of Medical Examiners proposes to review Chapter 171, (§§171.1-171.7), concerning Postgraduate Training Permit, pursuant to the Texas Government Code, §2001.039.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners contemporaneously proposes the repeal and replacement of Chapter 171.

The agency's reason for adopting the rules contained in this chapter continues to exist.

Comments on the proposed review may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018.

TRD-200405316
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: August 23, 2004

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The Texas State Board of Medical Examiners proposes to review Chapter 199, (§§199.1-199.4), concerning Public Information, pursuant to the Texas Government Code, §2001.039.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners contemporaneously proposes amendments to Chapter 199.

The agency's reason for adopting the rules contained in this chapter continues to exist.

Comments on the proposed review may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018.

TRD-200405318
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: August 23, 2004

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Adopted Rule Reviews

Texas Agriculture Resources Protection Authority

Title 4, Part 7

The Board of Directors of the Agriculture Resources Protection Authority (ARPA Board) adopts the review of Title 4, Texas Administrative Code, Part 7, Chapter 101, concerning General Rules, pursuant to the Texas Government Code, §2001.039, without changes to its Notice of Intent to Review, as published in the June 25, 2004, issue of the *Texas Register* (29 TexReg 6127). No comments were received on the proposed review.

Section 2001.039, requires that state agencies review and consider for readoption each of their rules every four years. The review must include an assessment of whether the original justification for the rules continues to exist. The assessment of Title 4, Part 7, Chapter 101, by the ARPA Board at this time indicates that the reason for readopting without changes all sections in Title 4, Part 7, Chapter 101 continues to exist.

TRD-200405241
Dolores Alvarado Hibbs
Deputy General Counsel, Texas Department of Agriculture
Texas Agriculture Resources Protection Authority
Filed: August 19, 2004

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Texas State Board of Medical Examiners

Title 22, Part 9

The Texas State Board of Medical Examiners adopts the review of Chapter 186, (§186.1), concerning Supervision of Physician Assistant Students, pursuant to the Texas Government Code, §2001.039.

The proposed review was published in the April 23, 2004, issue of the *Texas Register* (29 TexReg 3979).

No comments were received regarding adoption of the review.

The agency's reason for adopting the rules contained in this chapter continues to exist.

This concludes the review of Chapter 186, Supervision of Physician Assistant Students.

TRD-200405304
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: August 23, 2004

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State Seed and Plant Board

Title 4, Part 5

The State Seed and Plant Board of the Texas Department of Agriculture (the department) adopts the review of Title 4, Texas Administrative Code, Part 5, Chapter 81, concerning Certification Procedures and Chapter 82, concerning Administrative Procedures, pursuant to the Texas Government Code, §2001.039, without changes to the proposed notice of intention to review published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6749). No comments were received on the proposal

Section 2001.039 requires state agencies to review and consider for readoption each of their rules every four years. The review must include an assessment of whether the original justification for the rules continues to exist. The State Seed and Plant Board and the department have determined that the reason for readopting without changes all sections in Title 4, Part 5, Chapters 81 and 82 continue to exist.

TRD-200405357
Dolores Alvarado Hibbs
Deputy General Counsel
State Seed and Plant Board
Filed: August 24, 2004

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Texas Workers' Compensation Commission

Title 28, Part 2

In accordance with the General Appropriation Act, Article IX, §167, 75th Legislature, the General Appropriations Act, §9-10, 76th Legislature, and Texas Government Code §2001.039 as added by SB-178, 76th Legislature, and pursuant to the notice of intention to review published in the May 21, 2004 issue of the *Texas Register*, (29 TexReg 5121), the Texas Workers' Compensation Commission (the commission) has assessed whether the reason for adopting or readopting these rules continues to exist. No comments were received regarding the review of these rules.

As a result of the review, the Commission has determined that the reason for adoption of these rules continues to exist. Therefore, the Commission readopts Chapter 147. If the Commission determines that the rules should be revised or repealed, the repeal or revisions of the rules will be accomplished in accordance with the Administrative Procedure Act.

CHAPTER 147 - DISPUTE RESOLUTION-AGREEMENTS, SETTLEMENTS, COMMUTATIONS

§147.1. Definitions.

§147.2. Form

§147.3. Execution.

§147.4. Filing Agreements with the Commission; Effective Dates.

§147.5. Filing Settlements with the Commission; Effective Dates.

§147.6. Settlement Conference.

§147.7. Effect on Previously Entered Decisions and Orders.

§147.8. Withdrawal from Settlement.

§147.9. Requirements for Agreements and Settlements.

§147.10. Commutation of Impairment Income Benefits.

§147.11. Notification of Commission of Proposed Judgments and Settlements.

TRD-200405325

Susan Cory

General Counsel

Texas Workers' Compensation Commission

Filed: August 23, 2004

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In accordance with the General Appropriation Act, Article IX, §167, 75th Legislature, the General Appropriations Act, §9-10, 76th Legislature, and Texas Government Code §2001.039 as added by SB-178, 76th Legislature, and pursuant to the notice of intention to review published in the May 21, 2004 issue of the *Texas Register*, (29 TexReg 5121), the Texas Workers' Compensation Commission (the commission) has assessed whether the reason for adopting or readopting these rules continues to exist. No comments were received regarding the review of these rules.

As a result of the review, the Commission has determined that the reason for adoption of these rules continues to exist. Therefore, the Commission readopts Chapter 152. If the Commission determines that the rules should be revised or repealed, the repeal or revisions of the rules will be accomplished in accordance with the Administrative Procedure Act.

CHAPTER 152 - ATTORNEYS' FEES

§152.1. Attorney Fees: General Provisions.

§152.2. Attorney Fees: Representation of Claimants.

§152.3. Approval or Denial of Fee by the Commission.

§152.4. Guidelines for Legal Services Provided to Claimants and Carriers.

§152.5. Allowable Expenses.

TRD-200405326

Susan Cory

General Counsel

Texas Workers' Compensation Commission

Filed: August 23, 2004

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TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 16 TAC §68.80(b)

Construction Cost	Review Fee	Inspection Fee
$ 50,000 – $ 200,000	$250	$350
$ 200,001 – $ 500,000	$315	$375
$ 500,001 – $ 1,000,000	$380	$400
$ 1,000,001 – $ 5,000,000	$445	$445
$ 5,000,001 – $10,000,000	$575	$575
$10,000,001 – $15,000,000	$620	$620
$15,000,001 – $25,000,000	$785	$785
$25,000,001 – $50,000,000	$955	$955
$50,000,001 – $75,000,000	$1,175	$1,175
> $75,000,000	Contact TDLR for negotiated fee	

Inspection of State Leases (no construction involved)	- $225 per lease
Preliminary Review Fee	- $145 each
Special Inspection Fee	- $215 per hour, one hour minimum
Variance Application Fee	- $175 each
Variance Appeal Fee	- $200
Project Filing Fee	- $175
Late Project Filing Fee	- $300
Replacement Notices	- $ 25 each

Registered Accessibility Specialist:

	Single Endorsement	Dual Endorsement
Application for Certificate of Registration	- $200	$300
Registration Renewal	- $150	$250
Texas Accessibility Academy Entrance Fee	- $150	
Examination	- $100	
Wall Certificate Duplicate or Replacement	- $ 25	
Wallet Card Duplicate or Replacement	- $ 25	
Revised Registration	- $ 25	
Add or Subtract Endorsement	- $ 25	

Figure: 22 TAC §51.3(b)

PENALTIES FOR PRACTICE AND PROCEDURES VIOLATIONS

CATEGORY I

Not To Exceed The Following Amounts

1st: $750 **2nd: $850** **3rd: $1000**

Violation	**Reference**
Unlicensed Barber School	TEX. OCC. CODE ANN. §1601.351
Enrolling Prior to Approval	TEX. OCC. CODE ANN. §1601.356
Unapproved Location Change	TEX. OCC. CODE ANN. §1601.554

CATEGORY II

Not To Exceed The Following Amounts

1st: $500 **2nd: $750** **3rd: $1000**

Violation	**Reference**
Registered Name/Location	TEX. OCC. CODE ANN. §1601.301
Certificate, License or Permit Required	TEX. OCC. CODE ANN. §1601.251
Unlicensed Barber Shop	TEX. OCC. CODE ANN. §1601.301
Unlawful Health Certificate	TEX. OCC. CODE ANN. §1601.701
Footspa Sanitation	TEX. OCC. CODE. ANN §1601.152

CATEGORY III

Not To Exceed The Following Amounts

1st: $500 **2nd: $750** **3rd: $1000**

Violation	**Reference**
Barber Tech Practicing Out of Scope	TEX. OCC. CODE ANN. §1601.256
Manicurist Practicing Out of Scope	TEX. OCC. CODE ANN. §1601.257
Unlicensed Manicure Shop	TEX. OCC. CODE ANN. §1601.304

Gross Malpractice	TEX. OCC. CODE ANN. §1601.601
Knowingly Contagious Disease	TEX. OCC. CODE ANN. §1601.601
Employing Unlicensed Person	TEX. OCC. CODE ANN. §1601.701
Obtaining License by Fraud	TEX. OCC. CODE ANN. §1601.701
Misrepresent Enrollment	TEX. OCC. CODE ANN. §1601.562

CATEGORY IV

Not To Exceed The Following Amounts

1st: $300 **2nd: $500** **3rd: $750**

Violation	**Reference**
Sleeping Quarters	TEX. OCC. CODE ANN. §1601.507
False Advertisement "Barbering"	TEX. OCC. CODE ANN. §1601.251
False Advertisement "Barber Pole"	TEX. OCC. CODE ANN. §1601.251
False Statement	TEX. OCC. CODE ANN. §1601.252
False Advertisement	TEX. OCC. CODE ANN. §1601.601
Practicing Under Wrong Name	TEX. OCC. CODE ANN. §1601.601
Refresher Course	TEX. OCC. CODE ANN. §1601.354
Theory Taught	TEX. OCC. CODE ANN. §1601.558
Teacher on Duty	TEX. OCC. CODE ANN. §1601.560
Qualified Instructor	TEX. OCC. CODE ANN. §1601.560
Teacher Instructor Ratio	TEX. OCC. CODE ANN. §1601.560
School Change of Ownership	TEX. OCC. CODE ANN. §1601.554
Increase/Decrease Hours	TEX. OCC. CODE ANN. §1601.558(d)

CATEGORY V

Not To Exceed The Following Amounts

1st: $200 **2nd: $400** **3rd: $500**

Violation	**Reference**

Stop Blood Flow	TEX. OCC. CODE ANN. §1601.506

CATEGORY VIA

Not To Exceed The Following Amounts

1st: $100 **2nd: $300** **3rd: $500**

Violation	**Reference**
Employee with Disease	TEX. OCC. CODE ANN. §1601.505
Expired License	TEX. OCC. CODE ANN. §1601.402
Unlawful Transfer	TEX. OCC. CODE ANN. §1601.308
Proof of Requisites	TEX. OCC. CODE ANN. §1601.252
Employing Cosmetologist	TEX. OCC. CODE ANN. §1601.309
Expired Permit	TEX. OCC. CODE ANN. §1601.408
Location Change	TEX. OCC. CODE ANN. §1601.310
School Owner Working Chair	TEX. OCC. CODE ANN. §1601.701
School Owner Permitting A Person Other Than A Student To Work Chair	TEX. OCC. CODE ANN. §1601.701

CATEGORY VIB

Not To Exceed The Following Amounts

1st: $100 **2nd: $300** **3rd: $500**

Violation	**Reference**
Liquid Sterilizer	TEX. OCC. CODE ANN. §1601.353
Barber School Sign	TEX. OCC. CODE ANN. §1601.553
Expired School License	TEX. OCC. CODE ANN. §1601.407
Course Outline	TEX. OCC. CODE ANN. §1601.556
Student Information	TEX. OCC. CODE ANN. §1601.556
Curriculum Content	TEX. OCC. CODE ANN. §1601.557
Student Cancellation	TEX. OCC. CODE ANN. §1601.562
Violation of Refund Policy	TEX. OCC. CODE ANN. §1601.563

Violate Termination Ratio	TEX. OCC. CODE ANN. §1601.564
Student Re-Entry	TEX. OCC. CODE ANN. §1601.564
Timely Refund	TEX. OCC. CODE ANN. §1601.566
Interest Paid	TEX. OCC. CODE ANN. §1601.566
Incomplete/Re-Entry	TEX. OCC. CODE ANN. §1601.565

CATEGORY VIC

Not To Exceed The Following Amounts

1st: $100 **2nd: $200** **3rd: $300**

Violation	**Reference**
Practice Unlicensed Facility	TEX. OCC. CODE ANN. §1601.453
Cosmetologist Practicing in Barber Shop	TEX. OCC. CODE ANN. §1601.502
Equipment	TEX. OCC. CODE ANN. §1601.504
Combs, Brushes	TEX. OCC. CODE ANN. §1601.506
Sterilize Razor, Shears Clippers, Tweezers	TEX. OCC. CODE ANN. §1601.506
Shave Inflamed Area	TEX. OCC. CODE ANN. §1601.506
Dirty Finger Bowl	TEX. OCC. CODE ANN. §1601.506
Unlawful Location Change	TEX. OCC. CODE ANN. §1601.503
16 Years Old	TEX. OCC. CODE ANN. §1601.253 and §1601.701

CATEGORY VID

Not To Exceed The Following Amounts

1st: $50 **2nd: $100** **3rd: $150**

Violation	**Reference**
Failure to Display	TEX. OCC. CODE ANN. §1601.701
Display of Consumer Complaint	TEX. OCC. CODE ANN. §1601.202
Unlaundered Towel	TEX. OCC. CODE ANN. §1601.506
Dirty Head Rest	TEX. OCC. CODE ANN. §1601.506

Dirty Sponge	TEX. OCC. CODE ANN. §1601.506
No Neck Strip	TEX. OCC. CODE ANN. §1601.506
Failure To Display	TEX. OCC. CODE ANN. §1601.451

CATEGORY VIIA

Not To Exceed The Following Amounts

1st: $250 [~~Warning~~] **2nd: $500** **3rd: $1000**

Violation	**Reference**
All Furniture and Equipment	TEX. OCC. CODE ANN. §1601.506

CATEGORY VIIB

Not To Exceed The Following Amounts

1st: Warning **2nd: $100** **3rd: $150**

Violation	**Reference**
Manager on Duty	TEX. OCC. CODE ANN. §1601.502
Improper Curriculum	TEX. OCC. CODE ANN. §1601.354
Theory/Practical Instruction	TEX. OCC. CODE ANN. §1601.558
2800 Square Feet	TEX. OCC. CODE ANN. §1601.353
Twenty Chairs	TEX. OCC. CODE ANN. §1601.353
[~~One Lavatory per Two chairs~~]	[~~TEX. OCC. CODE ANN. §1601.353~~]

CATEGORY VIIC

Not To Exceed The Following Amounts

1st: Warning **2nd: $100** **3rd: $200**

Violation	**Reference**
Shop Permit on Display	TEX. OCC. CODE ANN. §1601.501
Classroom Requirements	TEX. OCC. CODE ANN. §1601.353
Library Facilities	TEX. OCC. CODE ANN. §1601.353

Drinking Fountain	TEX. OCC. CODE ANN. §1601.353
Fire Fighting Equipment	TEX. OCC. CODE ANN. §1601.353
Student Requirements	TEX. OCC. CODE ANN. §1601.260
Progress Reports	TEX. OCC. CODE ANN. §1601.561
Completion Rates	TEX. OCC. CODE ANN. §1601.561
Job Placement	TEX. OCC. CODE ANN. §1601.561
[~~Hard Surface Floor~~]	[~~TEX. OCC. CODE ANN. §1601.353~~]
Lighting	TEX. OCC. CODE ANN. §1601.353

CATEGORY VIID

Not To Exceed The Following Amounts

1st: Warning **2nd: $50** **3rd: $100**

Violation	**Reference**
Adequate Latherizers	TEX. OCC. CODE ANN. §1601.353

CATEGORY VIIE

Not To Exceed The Following Amounts

1st: $50 **2nd: $100** **3rd: $150**

Violation	**Reference**
One Lavatory (Sink) per two chairs	TEX. OCC. CODE ANN. §1601.353

CATEGORY VIIF

Not To Exceed The Following Amounts

1st: $50 **2nd: $100** **3rd: $200**

Violation	**Reference**
Hard Surface Floor	TEX. OCC. CODE ANN. §1601.353

GENERAL RULES OF PRACTICE AND PRACEDURES

CATEGORY I

Not To Exceed The Following Amounts

1st: $750	2nd: $850	3rd: $1000

CATEGORY II

Not To Exceed The Following Amounts

1st: $500	2nd: $750	3rd: $1000

Violation	Reference
Right of Access	§51.6

CATEGORY III

Not To Exceed The Following Amounts

1st: $300	2nd: $500	3rd: $750

Violation	Reference
Barber Advertisements (Yellow Pages)	§51.101

CATEGORY IV

Not To Exceed The Following Amounts

1st: $200	2nd: $400	3rd: $500

CATEGORY VA

Not To Exceed The Following Amounts

1st: $100	2nd: $300	3rd: $500

CATEGORY VB

Not To Exceed The Following Amounts

1st: $100	2nd: $200	3rd: $300

Violation	Reference
Animals Prohibited	§51.96

CATEGORY VC

Not To Exceed The Following Amounts

1st: $50 **2nd: $100** **3rd: $150**

Violation	Reference
Current Address	§51.4

CATEGORY VIA

Not To Exceed The Following Amounts

1st: Warning **2nd: $500** **3rd: $1000**

CATEGORY VIB

Not To Exceed The Following Amounts

1st: Warning **2nd: $300** **3rd: $500**

Violation	Reference
Barber School Business Hours	§51.14
Other Business Prohibited (School or College)	§51.40
Booth Rental	§51.97

CATEGORY VIC

Not To Exceed The Following Amounts

1st: Warning **2nd: $100** **3rd: $200**

Violation	Reference
Student Equipment	§51.16
Dress Code	§51.94

CATEGORY VID

Not To Exceed The Following Amounts

1st: Warning	**2nd: $50**	**3rd: $100**
Violation	**Reference**	
Student Certification	§51.23	
[~~Other Business Prohibited (Shop)~~]	[~~§51.95~~]	

CATEGORY VIE

Not To Exceed The Following Amounts

1st: $25	**2nd: $50**	**3rd: $100**
Violation	**Reference**	
Other Business Prohibited (Shop)	§51.95	

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in 303.003, 303.009, and 304.003, Tex. Fin. Code.

The weekly ceiling as prescribed by Sec. 303.003 and Sec. 303.009 for the period of 08/30/04 - 09/05/04 is 18% for Consumer [1]/Agricultural/Commercial [2]/credit thru $250,000.

The weekly ceiling as prescribed by Sec. 303.003 and Sec. 303.009 for the period of 08/30/04 - 09/05/04 is 18% for Commercial over $250,000.

The judgment ceiling as prescribed by Sec. 304.003 for the period of 09/01/04 - 09/30/04 is 5% for Consumer/Agricultural/Commercial/credit thru $250,000.

The judgment ceiling as prescribed by Sec. 304.003 for the period of 09/01/04 - 09/30/04 is 5% for Commercial over $250,000.

[1] Credit for personal, family or household use.

[2] Credit for business, commercial, investment or other similar purpose.

TRD-200405350
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: August 24, 2004

♦ ♦ ♦

East Texas Council of Governments

Request for Proposals to Interested Entities for Worker Training Initiative

This Request for Proposals to interested entities is filed under Government Code 2254.

Notice is given that as the administrative unit for the East Texas Workforce Development Board, the East Texas Council of Governments (ETCOG) is soliciting proposals for worker training initiatives with primary companies. Funding is available to provide access to targeted training dollars for both current and newly hired workers. The Skills Advancement Fund of East Texas (SAFE) is intended as an avenue for primary companies throughout the East Texas WDA to access funding to provide worker training by partnering with providers such as local community colleges or to train workers in-house. The term "primary company" as described in the Request for Proposals, is synonymous with the definition cited in Texas legislation. As applied to the fourteen-county East Texas Workforce Development Area, it refers to a company in an identified industry that manufactures a product or provides a service where at least 50% of sales come from outside the area.

The East Texas Workforce Development Board is responsible for the oversight of state and federally funded training, employment, and childcare services in a fourteen county area around Longview and Tyler.

Persons or organizations wanting to receive a Request for Proposals (RFP) package should inquire by letter, fax, or email to East Texas Council of Governments, 3800 Stone Road, Kilgore, Texas 75662, Attn: Daniel Pippin. The fax number for ETCOG is (903) 983-1440. The email address is Daniel.Pippin@twc.state.tx.us. Questions regarding the RFP process can be addressed by calling (903) 984-8641.

A bidders conference will take place on Wednesday, September 8, 2004 at 1:30 p.m. It is anticipated that the deadline for receipt of proposals shall be 5:00 p.m. CDT, Monday, September 20, 2004.

TRD-200405352
Glynn Knight
Executive Director
East Texas Council of Governments
Filed: August 24, 2004

♦ ♦ ♦

Texas Commission on Environmental Quality

Notice of Costs to Administer the Voluntary Cleanup Program

In accordance with Solid Waste Disposal Act, §361.613, Subchapter S, the executive director of the Texas Commission of Environmental Quality (TCEQ or commission) shall calculate and publish annually the commission's costs to administer the Voluntary Cleanup Program. The executive director of TCEQ shall also calculate and publish annually a rate established for the purposes of identifying the costs recoverable by the commission for the Innocent Owner/Operator Program, based on authority from Solid Waste Disposal Act, §361.752(b). The TCEQ is publishing the hourly billing rate of $107 for both the Voluntary Cleanup Program and the Innocent Owner/Operator Program for Fiscal Year 2005.

The Voluntary Cleanup Law was effective September 1, 1995, and as such, this will be the tenth year of operation for the program. The commission is able to use data from the previous nine years to calculate the rate for Fiscal Year 2005. The Innocent Owner/Operator Program Law was effective September 1, 1997. As such, this will be the eighth year of operation for the program. Therefore, the commission will be able to use data from the previous seven years to calculate the rate for Fiscal Year 2005. A single hourly billing rate for both programs was derived from current projections for salaries plus the fringe benefit rate and the indirect cost rate, less federal funding divided by the estimated billable salary hours. The hourly rate for the two programs was calculated, and then rounded to a whole dollar amount. Billable salary hours were derived by subtracting the release time hours from the total available hours and a further reduction of 37.80% to account for non-site specific hours. The release time includes sick leave, jury duty, holidays, etc., and is set at 19.54% (actual rate for Fiscal Year 2003). The current fringe benefit rate is 25.30%. Fringe benefits include retirement, social security, and insurance expenses and are calculated at a rate that applies to the agency as a whole. The proposed indirect cost rate is 33.50%. Indirect costs include allowable overhead expenses and are also calculated at a rate that applies to the whole agency. The billings processed for Fiscal Year 2005 will use the hourly billing rate of $107 for both the Voluntary Cleanup Program and the Innocent Owner/Operator Program and will not be adjusted. All travel related expenses will be billed as a separate

expense. After an applicant's initial $1,000 application fee has been expended by the Innocent Owner/Operator Program or the Voluntary Cleanup Program review and oversight, invoices will be sent to the applicant on a monthly basis for payment of additional program expenses.

The commission anticipates receiving federal funding during Fiscal Year 2005 for the continued development and enhancement of the Voluntary Cleanup Program and the Innocent Owner/Operator Program. If the federal funding anticipated for Fiscal Year 2005 does not become available, the commission may publish a new rate. Federal funding of the Voluntary Cleanup Program and the Innocent Owner/Operator Program should occur prior to October 1, 2004.

For more information, please contact Mr. Jay Carsten, P.G., Texas Commission on Environmental Quality, Voluntary Cleanup Section, Remediation Division, MC 221, 12100 Park 35 Circle, Austin, Texas 78753 or call (512) 239-5873.

TRD-200405367

Stephanie Bergeron

Director, Environmental Law Division

Texas Commission on Environmental Quality

Filed: August 24, 2004

♦ ♦ ♦

Notice of District Petition

Notices mailed August 18, 2004

TCEQ Internal Control No. 07022004-D01; Wylie Northeast Water Supply Corporation (Petitioner) has filed a petition with the Texas Commission on Environmental Quality (TCEQ) to convert Wylie Northeast Water Supply Corporation to Wylie Northeast Special Utility District (District) and to transfer Certificate of Convenience and Necessity (CCN) No. 10192 from Wylie Northeast Water Supply Corporation to Wylie Northeast Special Utility District. Wylie Northeast Special Utility District's business address will be: P.O. Box 1029; Wylie, Texas 75098-1029. The petition was filed pursuant to Chapters 13 and 65 of the Texas Water Code; 30 Texas Administrative Code Chapters 291 and 293; and the procedural rules of the TCEQ. The nature and purpose of the petition are for the conversion of Wylie Northeast Water Supply Corporation and the organization, creation and establishment of Wylie Northeast Special Utility District under the provisions of Article XVI, Section 59, Texas Constitution, and Chapter 65 of the Texas Water Code, as amended. The District shall have the purposes and powers provided in Chapter 65 of the Texas Water Code, and CCN No. 10192 shall be transferred as provided in Chapter 13, of the Texas Water Code, as amended. The nature of the services presently performed by Wylie Northeast Water Supply Corporation is to purchase, own, hold, lease and otherwise acquire sources of water supply; to build, operate and maintain facilities for the transportation of water; and to sell water to individual members, towns, cities, private businesses, and other political subdivisions of the State. The nature of the services proposed to be provided by Wylie Northeast Special Utility District is to purchase, own, hold, lease, and otherwise acquire sources of water supply; to build, operate, and maintain facilities for the storage, treatment, and transportation of water; and to sell water to individuals, towns, cities, private business entities and other political subdivisions of the State. Additionally, it is proposed that the District will protect, preserve and restore the purity and sanitary condition of the water within the District. It is anticipated that conversion will have no adverse effects on the rates and services provided to the customers. The proposed District is located in Collin County and will contain approximately 4.214 square miles. The territory to be included within the proposed District includes all of the singularly certified service area covered by CCN No. 10192. CCN No. 10192 will be transferred after a positive confirmation election.

TCEQ Internal Control No. 07142004-D01; New Hope Water Supply Corporation (Petitioner) has filed a petition with the Texas Commission on Environmental Quality (TCEQ) to convert New Hope Water Supply Corporation to New Hope Special Utility District (District) and to transfer Certificate of Convenience and Necessity (CCN) No. 10485 from New Hope Water Supply Corporation to New Hope Special Utility District. New Hope Special Utility District's business address will be: 431 CR 2651; Mineola, Texas 75773-4809. The petition was filed pursuant to Chapters 13 and 65 of the Texas Water Code; 30 Texas Administrative Code Chapters 291 and 293; and the procedural rules of the TCEQ. The nature and purpose of the petition are for the conversion of New Hope Water Supply Corporation and the organization, creation and establishment of New Hope Special Utility District under the provisions of Article XVI, Section 59, Texas Constitution, and Chapter 65 of the Texas Water Code, as amended. The District shall have the purposes and powers provided in Chapter 65 of the Texas Water Code, and CCN No. 10485 shall be transferred as provided in Chapter 13, of the Texas Water Code, as amended. The nature of the services presently performed by New Hope Water Supply Corporation is to purchase, own, hold, lease and otherwise acquire sources of water supply; to build, operate and maintain facilities for the transportation of water; and to sell water to individual members, towns, cities, private businesses, and other political subdivisions of the State. The nature of the services proposed to be provided by New Hope Special Utility District is to purchase, own, hold, lease, and otherwise acquire sources of water supply; to build, operate, and maintain facilities for the storage, treatment, and transportation of water; and to sell water to individuals, towns, cities, private business entities and other political subdivisions of the State. Additionally, it is proposed that the District will protect, preserve and restore the purity and sanitary condition of the water within the District. It is anticipated that conversion will have no adverse effects on the rates and services provided to the customers. The proposed District is located in Wood County and will contain approximately 38.4 square miles. The territory to be included within the proposed District includes all of the singularly certified service area covered by CCN No. 10485. CCN No. 10485 will be transferred after a positive confirmation election.

INFORMATION SECTION

The TCEQ may grant a contested case hearing on a petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed district's boundaries. You may also submit your proposed adjustments to the petition which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below.

The Executive Director may approve a petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of the notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court.

Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, the same address. For additional information, individual members of the general public may contact the Office of Public Assistance, at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-200405359
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: August 24, 2004

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Proposal for Decision

The State Office of Administrative Hearings issued a Proposal for Decision and Order to the Texas Commission on Environmental Quality on August 23, 2004, in the matter of the Executive Director of the Texas Commission on Environmental Quality, Petitioner v. Rudd Country, Inc. dba Rudd's Country Store 2; SOAH Docket No. 582-04-5439; TCEQ Docket No. 2003-1182- PWS-E. The commission will consider the Administrative Law Judge's Proposal for Decision and Order regarding the enforcement action against Rudd Country, Inc. dba Rudd's Country Store 2 on a date and time to be determined by the Office of the Chief Clerk in Room 201S of Building E, 12100 N. Interstate 35, Austin, Texas. This posting is Notice of Opportunity to Comment on the Proposal for Decision and Order. The comment period will end 30 days from date of this publication. Written public comments should be submitted to the Office of the Chief Clerk, MC-105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. If you have any questions or need assistance, please contact Paul Munguia, Office of the Chief Clerk, (512) 239-3300.

TRD-200405358
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: August 24, 2004

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General Land Office

Notice of Award for Consulting Services - Real Estate Investment Consulting Services

In accordance with Chapter 2254 of the Texas Government Code, the Texas General Land Office (GLO) files this notice of a consultant contract award. The Invitation for Consultant Services was published in the February 20, 2004, edition of the *Texas Register* (29 TexReg 1708). The General Land Office (GLO), under the direction of the School Land Board (SLB), is authorized by Tex. Nat. Res. Code §§51.401 et. seq. to invest a portion of the income from state lands dedicated to the Permanent School Fund (PSF) in real estate assets. This income is placed into a special fund account of the PSF (the Special Fund Account) for use to acquire fee or lesser interests in real property. The GLO has selected The Townsend Group, M.K. Ferguson Plaza, 1500 W. 3rd Street, Suite 410, Cleveland, Ohio 44118, to assist the GLO and SLB in drafting a comprehensive Investment Policy Statement for the Special Fund Account to ensure that funds from the account are invested in a prudent manner and in accordance with the best practices of comparable real estate funds. The Investment Policy Statement will include: Investment Strategies and Guidelines, Performance Measurement Benchmarks, and Reporting Procedures and Mechanisms. The payment for services is $15,000.00 for FY2004 and $100,000.00 for FY2005. Further information about the project may be obtained from Bo Tanner, General Land Office, (512) 463-9382.

TRD-200405258
Larry L. Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Filed: August 20, 2004

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Texas Department of Health

Correction of Error

In the July 30, 2004, issue of the *Texas Register* (29 TexReg 7412), the Texas Department of Health adopted an amendment to 25 TAC §289.260. Due to a coding error in the agency submission, the symbol "&" that follows the word "Dun" in §289.260(d)(2)(B), page 7415, column 2, was published as "amp;".

The sentence should read:

"If an applicant or licensee..., Industry NORM and Key Business Ratios, Dun & Bradstreet Industry publications,..."

TRD-200405379

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Correction of Error

In the July 30, 2004, issue of the *Texas Register* (29 TexReg 7427), the Texas Department of Health adopted new 25 TAC §289.301. Due to an error in the agency submission, the word "transferred" was omitted after the phrase "and if" in §289.301(k)(3)(B) on page 7437, column 1.

Subparagraph (B) should read as follows:

"(B) submit to the agency a record of the disposition of the lasers, if applicable, and if transferred, to whom it was transferred within 30 days following the expiration date."

TRD-200405380

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Correction of Error

In the July 30, 2004, issue of the *Texas Register* (29 TexReg 7346), the Texas Department of Health adopted an amendment to 25 TAC §289.232. Due to an error in the agency submission, Figure: 25 TAC §289.232(i)(6)(E)(i)(I) was published on page 7477 with incorrect numerical values for the first five entries in the right-most column of the table.

Under the column entitled Measure Half-Value Layer (millimeters of aluminum):

The first 1.5 should read 0.3;

The second 1.5 should read 0.4;

The third 1.5 should read 0.5;

The fourth 1.5 should read 1.2; and

The fifth 1.5 should read 1.3.

We are republishing the table with the corrections.

Figure: 25 TAC §289.232(i)(6)(E)*(i)(I)*

TABLE I. HALF-VALUE LAYER FOR SELECTED KILOVOLT PEAK

X-ray tube voltage (kilovolt peak)		Measure Half-Value Layer (millimeters of aluminum)
Designed operating range	Measured operating potential	
Below 51 --------	30	0.3
	40	0.4
	50	0.5
51 to 70 --------	51	1.2
	60	1.3
	70	1.5
Above 70 --------	71	2.1
	80	2.3
	90	2.5
	100	2.7
	110	3.0
	120	3.2
	130	3.5
	140	3.8
	150	4.1

TRD-200405381

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Notice of Amendment Number 46 to the Radioactive Material License of Nuclear Sources and Services, Inc. dba NSSI/Sources and Services, Inc.

Notice is hereby given by the Texas Department of Health (department), Bureau of Radiation Control, that it has amended Radioactive Material License Number L01811 issued to Nuclear Sources and Services, Inc., doing business as NSSI/Sources and Services, Inc., located at 5711 Etheridge in Houston, Texas.

Amendment number 46 is issued to clarify and elaborate on the requirements for financial assurance (FA) added in the preceding Amendment number 45. These conditions also contain necessary administrative provisions to implement the financial assurance requirements.

The department has determined that the amendment of the license, Title 25, Texas Administrative Code (TAC), Chapter 289, and the documentation submitted by the licensee provide reasonable assurance that the licensee's radioactive waste facility is operated in accordance with the requirements of 25 TAC, Chapter 289; the amendment of the license will not be inimical to the health and safety of the public or the environment; and the activity represented by the amendment of the license will not have a significant effect on the human environment.

This notice affords the opportunity for a public hearing upon written request within 30 days of the date of publication of this notice by a person affected as required by Texas Health and Safety Code, §401.116, and as set out in 25 TAC, §289.205(f). A "person affected" is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to a county, in which the radioactive material is or will be located; or doing business or has a legal interest in land in the county or adjacent county.

A person affected may request a hearing by writing Mr. Richard A. Ratliff, P.E., Chief, Bureau of Radiation Control, 1100 West 49th Street, Austin, Texas, 78756-3189. Any request for a hearing must contain the name and address of the person who considers himself affected by this action, identify the subject license, specify the reasons why the person considers himself affected, and state the relief sought. If the person is represented by an agent, the name and address of the agent must be stated. Should no request for a public hearing be timely filed, the agency action will be final.

A public hearing, if requested, shall be conducted in accordance with the provisions of Texas Health and Safety Code, §401.114, the Administrative Procedure Act (Chapter 2001, Texas Government Code), the formal hearing procedures of the department (25 TAC, §§1.21et seq.) and the procedures of the State Office of Administrative Hearings (1 TAC, Chapter 155).

A copy of the license amendment and supporting materials are available, by appointment, for public inspection and copying at the office

of the Bureau of Radiation Control, Texas Department of Health, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, 8:00 a.m. to 5:00 p.m., Monday-Friday (except holidays). Information relative to inspection and copying the documents may be obtained by contacting Chrissie Toungate, Custodian of Records, Bureau of Radiation Control.

TRD-200405370
Susan K. Steeg
General Counsel
Texas Department of Health
Filed: August 25, 2004

♦ ♦ ♦

Texas Health and Human Services Commission

Public Notice Statement

The Texas Health and Human Services Commission announces its intent to submit CHIP State Plan Amendment to that will add the option to provide a PCP, primary care physician, as a value-added service under the CHIP EPO (exclusive provider organization) contract. This amendment will be effective September 1, 2004 and will be included in the contracts that are executed under the Medicaid CHIP Joint Procurement.

For further information, contact Marianna Zolondek, Texas Health and Human Services Commission, 1100 West 49th Street, Austin, Texas 78756, (512) 491-1320 or marianna.zolondek@hhsc.state.tx.us.

TRD-200405351
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: August 24, 2004

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Texas Department of Housing and Community Affairs

Request for Proposal for Tax Credit Counsel

SUMMARY. The Texas Department of Housing and Community Affairs (TDHCA), through its Legal Services Division, is issuing a Request for Proposals (RFP) for outside counsel in connection with TDHCA's administration of its low income housing tax credit matters.

DEADLINE FOR SUBMISSION. The deadline for submission in response to the Request for Proposals is 4:00 p.m., Central Daylight Saving Time, September 17, 2004. No proposal received after the deadline will be considered.

TDHCA reserves the right to accept or reject any (or all) proposals submitted. The information contained in this proposal request is intended to serve only as a general description of the services desired by TDHCA, and TDHCA intends to use responses as a basis for further negotiation of specific project details with offerors. This request does not commit TDHCA to pay for any costs incurred prior to the execution of a contract and is subject to availability of funds. Issuance of this request for proposals in no way obligates TDHCA to award a contract or to pay any costs incurred in the preparation of a response.

Law firms interested in submitting a proposal should contact Mr. Chris Wittmayer, General Counsel, at 512/475-3948, 507 Sabine, Suite 900, Austin, TX 78701 or visit our website at www.tdhca.state.tx.us., for a complete copy of the RFP. Communication with any member of the board, the executive director, or TDHCA staff other than Mr. Wittmayer, concerning any matter related to this request for proposals is grounds for immediate disqualification.

TRD-200405371
Edwina P. Carrington
Executive Director
Texas Department of Housing and Community Affairs
Filed: August 25, 2004

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Texas Department of Insurance

Company Licensing

Application to change the name of SPECIALTY RISK INSURANCE COMPANY to PROGRESSIVE CHOICE INSURANCE COMPANY, a foreign fire and/or casualty company. The home office is in Mayfield Village, Ohio.

Any objections must be filed with the Texas Department of Insurance, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, M/C 305-2C, Austin, Texas, 78701, within 20 days after this notice is published in the *Texas Register*.

TRD-200405376
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: August 25, 2004

♦ ♦ ♦

Third Party Administrator Application

The following third party administrator (TPA) application has been filed with the Texas Department of Insurance and is under consideration.

Application for admission to Texas of EMPLOYER SUPPORT SERVICES, INC., a foreign third party administrator. The home office is BATON ROUGE, LOUISIANA.

Any objections must be filed within 20 days after this notice is published in the *Texas Register*, addressed to the attention of Matt Ray, MC 107-1A, 333 Guadalupe, Austin, Texas 78701.

TRD-200405375
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: August 25, 2004

♦ ♦ ♦

Legislative Budget Board

Budget Execution Proposal

Pursuant to Texas Government Code §317.002 this budget execution order is hereby proposed for the following actions affecting items of appropriation made in House Bill 1, Chapter 1330, Acts of the 78th Legislature, Regular Session, 2003 as amended by House Bill 2, Section 3.02, Acts of the 78th Legislature, Third Called Session and House Bill 28, Article V, Acts of the 78th Legislature, Third Called Session:

Texas School for the Blind and Visually Impaired

1. We find that the insufficient funds for classroom instruction and related and support services at the Texas School for the Blind and Visually Impaired creates an emergency. We therefore propose that:

a. $457,660 in general revenue appropriations made in House Bill 1, Section 11.28(c), Article IX, Chapter 1330, Acts of the 78th Legislature, Regular Session, 2003, as added by House Bill 28, Article V, Acts of the 78th Legislature, Third Called Session, be transferred to the Texas School for the Blind and Visually Impaired for the fiscal biennium ending August 31, 2005 for Strategies A.1.1. Classroom Instruction, A.1.4. Related and Support Services, and C.1.1. Indirect Administration to meet this emergency; and

b. the Texas School for the Blind and Visually Impaired be authorized to expend during the fiscal year ending August 31, 2004, in addition to amounts appropriated in House Bill 1, Chapter 1330, Acts of the 78th Legislature, Regular Session, an amount not to exceed $231,000 out of appropriations made for the fiscal year ending August 31, 2005 in Strategies A.1.1. Classroom Instruction, A.1.4. Related and Support Services, and C.1.1. Indirect Administration to meet this emergency.

Health-related Institutions - Targeted Appropriation Levels

2. We further find that a lack of sufficient funding at health-related institutions creates an emergency. We therefore propose that the following amounts be transferred from general revenue appropriations made in House Bill 2, Section 3.02, Acts of the 78th Legislature, Third Called Session:

a. $4,503,301 to The University of Texas Southwestern Medical Center at Dallas for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

b. $13,220,618 to The University of Texas Medical Branch at Galveston for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

c. $6,252,893 to The University of Texas Health Science Center at Houston for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

d. $7,241,724 to The University of Texas Health Science Center at San Antonio for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

e. $5,644,983 to The University of Texas M.D. Anderson Cancer Center for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

f. $1,582,183 to The University of Texas Health Center at Tyler for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

g. $2,704,645 to Texas A&M University System Health Science Center for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

h. $1,975,326 to the University of North Texas Health Science Center at Fort Worth for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency;

i. $5,758,716 to Texas Tech University Health Sciences Center for the fiscal biennium ending August 31, 2005 for operating costs to meet this emergency; and

j. $2,342,809 to the Texas Higher Education Coordinating Board for the fiscal biennium ending August 31, 2005 for the purposes of strategy D.1.1. Baylor College of Medicine and Rider 7, page III-54, House Bill 1, Chapter 1330, Acts of the 78th Legislature, Regular Session, 2003, to meet this emergency.

Texas Excellence Fund and University Research Fund

3. We find that a lack of sufficient funding for institutional excellence and the support of research creates an emergency. We therefore propose that $11,633,294 from general revenue appropriations made in House Bill 1, Section 11.28(c), Article IX, Chapter 1330, Acts of the 78th Legislature, Regular Session, 2003, as added by House Bill 28, Article V, Acts of the 78th Legislature, Third Called Session, be transferred to the Texas Excellence Fund, for the purpose of allocations to eligible general academic institutions according to Section 62.055, Education Code, for the fiscal biennium ending August 31, 2005.

4. We find that a lack of sufficient funding for institutional excellence and the support of research creates an emergency. We therefore propose that $11,633,294 from general revenue appropriations made in House Bill 1, Section 11.28(c), Article IX, Chapter 1330, Acts of the 78th Legislature, Regular Session, 2003, as added by House Bill 28, Article V, Acts of the 78th Legislature, Third Called Session, be transferred to the University Research Fund for the purpose of allocations to eligible general academic institutions according to Section 62.075, Education Code, for the fiscal biennium ending August 31, 2005.

If approved by the Governor, this budget execution order expires on August 31, 2005.

Signed by David Dewhurst

Lieutenant Governor

Joint Chair, Legislative Budget Board

Signed by Tom Craddick

Speaker of the House

Joint Chair, Legislative Budget Board

I certify that this Budget Execution Proposal was adopted by the Legislative Budget Board on August 23, 2004, by the following vote:

On the part of the Senate: YEAS: 5 NAYS: 0

On the part of the House: YEAS: 5 NAYS: 0

Signed by John O'Brien

Deputy Director

Legislative Budget Board

Approved: _____

Date: _____

Rick Perry

Governor of Texas

TRD-200405349
John O'Brien
Deputy Director
Legislative Budget Board
Filed: August 23, 2004

♦ ♦ ♦

Texas Legislative Council

Order Concerning Revisions to Chapters 101-103, Government Code, Regarding Court Fees and Costs

As required by Section 104.002, Government Code, the Texas Legislative Council has prepared a final report of updates and corrections to the index of court fees and costs found in Chapters 101-103, Subtitle I, Government Code. The purpose of the report is to conform Chapters 101-103 to legislation that was enacted by the 78th Legislature in its Regular Session in 2003 or in its 1st, 2nd, 3rd, or 4th Called Session in 2003 or 2004 and that amended or repealed a law referenced by any of those chapters or added new law on court fees and costs. The revisions may also correct errors, renumber or reorganize as needed, or make

other nonsubstantive changes to improve the accuracy and readability of the chapters.

All comments submitted to the Texas Legislative Council in regard to the report have been fully considered.

This order is issued, filed with the secretary of state, and published on the Texas Legislative Council's Internet site as required by Section 104.002(h), Government Code. The order and the actions contained in the report take effect September 3, 2004.

The final report and this order are available on the Texas Legislative Council's Internet site under the Legal link at http://www.tlc.state.tx.us/tlc.htm. Any questions should be directed to Susan Alexander, Project Director, Index of Court Fees and Costs, Texas Legislative Council, P.O. Box 12128, Capitol Station, Austin, Texas 78711, or by telephone at (512) 463-1155.

TRD-200405356
Leonard Reese
General Counsel
Texas Legislative Council
Filed: August 24, 2004

♦ ♦ ♦

Texas Lottery Commission

Instant Game Number 441 "Player's Club"

1.0 Name and Style of Game.

A. The name of Instant Game No. 441 is "PLAYER'S CLUB". The play style in Game 1 Blackjack is "add up". The play style in Game 2 Slots is "key number match". The play style in Game 3 High Card is "yours beats theirs". The play style in Game 4 Snake Eyes is "add up". The play style in Game 5 Roulette is "key number match". The play style in the Bonus Play is "yours beats theirs".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 441 shall be $10.00 per ticket.

1.2 Definitions in Instant Game No. 441.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - One of the symbols which appears under the Latex Overprint on the front of the ticket. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $2.00, $5.00, $10.00, $15.00, $20.00, $50.00, $100, $500, $1,000, $10,000. $250,000, 2 CLUBS SYMBOL, 3 CLUBS SYMBOL, 4 CLUBS SYMBOL, 5 CLUBS SYMBOL, 6 CLUBS SYMBOL, 7 CLUBS SYMBOL, 8 CLUBS SYMBOL, 9 CLUBS SYMBOL, 10 CLUBS SYMBOL, J CLUBS SYMBOL, Q CLUBS SYMBOL, K CLUBS SYMBOL, A CLUBS SYMBOL, 2 SPADES SYMBOL, 3 SPADES SYMBOL, 4 SPADES SYMBOL, 5 SPADES SYMBOL, 6 SPADES SYMBOL, 7 SPADES SYMBOL, 8 SPADES SYMBOL, 9 SPADES SYMBOL, 10 SPADES SYMBOL, J SPADES SYMBOL, Q SPADES SYMBOL, K SPADES SYMBOL, A SPADES SYMBOL, 2 HEARTS SYMBOL, 3 HEARTS SYMBOL, 4 HEARTS SYMBOL, 5 HEARTS SYMBOL, 6 HEARTS SYMBOL, 7 HEARTS SYMBOL, 8 HEARTS SYMBOL, 9 HEARTS SYMBOL, 10 HEARTS SYMBOL, J HEARTS SYMBOL, Q HEARTS SYMBOL, K HEARTS SYMBOL, A HEARTS SYMBOL, 2 DIAMONDS SYMBOL, 3 DIAMONDS SYMBOL, 4 DIAMONDS SYMBOL, 5 DIAMONDS SYMBOL, 6 DIAMONDS SYMBOL, 7 DIAMONDS SYMBOL, 8 DIAMONDS SYMBOL, 9 DIAMONDS SYMBOL, 10 DIAMONDS SYMBOL, J DIAMONDS SYMBOL, Q DIAMONDS SYMBOL, K DIAMONDS SYMBOL, A DIAMONDS SYMBOL, CLOVER SYMBOL, BELL SYMBOL, STAR SYMBOL, HORSESHOE SYMBOL, CHERRY SYMBOL, SEVEN SYMBOL, BAR SYMBOL, COWBOY HAT SYMBOL, SPUR SYMBOL, 2 CARD SYMBOL, 3 CARD SYMBOL, 4 CARD SYMBOL 5 CARD SYMBOL, 6 CARD SYMBOL, 7 CARD SYMBOL, 8 CARD SYMBOL, 9 CARD SYMBOL, 10 CARD SYMBOL, J CARD SYMBOL, Q CARD SYMBOL, K CARD SYMBOL, A CARD SYMBOL, 2 DICE SYMBOL, 3 DICE SYMBOL, 4 DICE SYMBOL, 5 DICE SYMBOL, SIX DICE SYMBOL, ONE DICE SYMBOL, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30.

D. Play Symbol Caption - the small printed material appearing below each Play Symbol which explains the Play Symbol. One and only one of these Play Symbol Captions appear under the appropriate Play Symbol and each is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 441 - 1.2D

PLAY SYMBOL	CAPTION
$2.00	TWO$
$5.00	FIVE$
$10.00	TEN$
$15.00	FFTN
$20.00	TWENTY
$50.00	FIFTY
$100	ONEHUN
$500	FIVHUN
$1,000	ONETHOU
$10,000	10THOU
$250,000	250THOU
2 CLUBS CARD SYMBOL	TWO
3 CLUBS CARD SYMBOL	THR
4 CLUBS CARD SYMBOL	FOR
5 CLUBS CARD SYMBOL	FIV
6 CLUBS CARD SYMBOL	SIX
7 CLUBS CARD SYMBOL	SVN
8 CLUBS CARD SYMBOL	EGT
9 CLUBS CARD SYMBOL	NIN
10 CLUBS CARD SYMBOL	TEN
J CLUBS CARD SYMBOL	JAK
Q CLUBS CARD SYMBOL	QUN
K CLUBS CARD SYMBOL	KNG
A CLUBS CARD SYMBOL	ACE
2 SPADES CARD SYMBOL	TWO
3 SPADES CARD SYMBOL	THR
4 SPADES CARD SYMBOL	FOR
5 SPADES CARD SYMBOL	FIV
6 SPADES CARD SYMBOL	SIX
7 SPADES CARD SYMBOL	SVN
8 SPADES CARD SYMBOL	EGT
9 SPADES CARD SYMBOL	NIN
10 SPADES CARD SYMBOL	TEN
J SPADES CARD SYMBOL	JAK
Q SPADES CARD SYMBOL	QUN
K SPADES CARD SYMBOL	KNG
A SPADES CARD SYMBOL	ACE
2 HEARTS CARD SYMBOL	TWO
3 HEARTS CARD SYMBOL	THR
4 HEARTS CARD SYMBOL	FOR
5 HEARTS CARD SYMBOL	FIV
6 HEARTS CARD SYMBOL	SIX
7 HEARTS CARD SYMBOL	SVN
8 HEARTS CARD SYMBOL	EGT
9 HEARTS CARD SYMBOL	NIN
10 HEARTS CARD SYMBOL	TEN

J HEARTS CARD SYMBOL	JAK
Q HEARTS CARD SYMBOL	QUN
K HEARTS CARD SYMBOL	KNG
A HEARTS CARD SYMBOL	ACE
2 DIAMONDS CARD SYMBOL	TWO
3 DIAMONDS CARD SYMBOL	THR
4 DIAMONDS CARD SYMBOL	FOR
5 DIAMONDS CARD SYMBOL	FIV
6 DIAMONDS CARD SYMBOL	SIX
7 DIAMONDS CARD SYMBOL	SVN
8 DIAMONDS CARD SYMBOL	EGT
9 DIAMONDS CARD SYMBOL	NIN
10 DIAMONDS CARD SYMBOL	TEN
J DIAMONDS CARD SYMBOL	JAK
Q DIAMONDS CARD SYMBOL	QUN
K DIAMONDS CARD SYMBOL	KNG
A DIAMONDS CARD SYMBOL	ACE
CLOVER SYMBOL	CLOVER
BELL SYMBOL	BELL
STAR SYMBOL	STAR
HORSESHOE SYMBOL	H-SHOE
CHERRY SYMBOL	CHERRY
SEVEN SYMBOL	SEVEN
BAR SYMBOL	BAR
COWBOY HAT SYMBOL	HAT
SPUR SYMBOL	SPUR
2 SYMBOL	TWO
3 SYMBOL	THR
4 SYMBOL	FOR
5 SYMBOL	FIV
6 SYMBOL	SIX
7 SYMBOL	SVN
8 SYMBOL	EGT
9 SYMBOL	NIN
10 SYMBOL	TEN
J SYMBOL	JCK
Q SYMBOL	QUN
K SYMBOL	KING
A SYMBOL	ACE
2 DICE SYMBOL	TWO
3 DICE SYMBOL	THR
4 DICE SYMBOL	FOR
5 DICE SYMBOL	FIV
6 DICE SYMBOL	SIX
1 DICE SYMBOL	SNAKE
1 DICE SYMBOL	EYES

E. Retailer Validation Code - Three (3) small letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 441 - 1.2E

CODE	PRIZE
TEN	$10.00
FTN	$15.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a four (4) digit security number which will be boxed and placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $10.00, $15.00, or $20.00.

H. Mid-Tier Prize - A prize of $50.00, $100, or $500.

I. High-Tier Prize - A prize of $1,000, $10,000 or $250,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (441), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 074 within each pack. The format will be: 441-0000001-000.

L. Pack - A pack of "PLAYER'S CLUB" Instant Game tickets contain 75 tickets, which are packed in plastic shrink-wrapping and fanfolded in pages of one (1). There will be two (2) fanfold types for this game. Type A: The front of each pack will display ticket back 074, next page will consist of 073, etc. The back of each pack will display ticket front 000. Type B: The front of each pack will display ticket back 000. The back of each pack will display ticket front 074.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "PLAYER'S CLUB" Instant Game No. 441 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "PLAYER'S CLUB" Instant Game is determined once the latex on the ticket is scratched off to expose 86 (eighty-six) play symbols. In Game 1 Blackjack, the player must add up the cards symbols in each Player's HAND. If the total of the player's card symbols is higher than the DEALER'S card symbols in any HAND the player will win the Prize indicated for that HAND. J SYMBOL, Q SYMBOL, and K SYMBOL will equal 10; A SYMBOL will equal 11. In Game 2 Slots, if the player reveals three (3) identical play symbols in the same spin across the player will win the prize indicated in the SLOTS LEGEND for that spin. In Game 3 High Card, if the player's YOUR CARD play symbol is higher than the DEALER'S CARD play symbol within the same HAND, the player will win the prize indicated for that HAND. The Ace play symbol is high. In Game 4 Snake Eyes, if any roll in game 4 totals 7 or 11, the player will win the prize indicated for that roll. If the player reveals a SNAKE EYES symbol in any ROLL, the player will win all five (5) prizes in Game 4. In Game 5 Roulette, if the ROULETTE NUMBER play symbol is identical to any of the YOUR NUMBERS play symbols the player will win the prize indicated for that play symbol. In the Bonus Play, if the YOUR HAND play symbol is higher than the DEALER'S HAND play symbol, the player will win the prize indicated. The Ace is high. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 86 (eighty-six) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 86 (eighty-six) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 86 (eighty-six) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 86 (eighty-six) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. There is no relation between the position of a ticket in a book and its status (winner or non-winner).

B. Adjacent ticket within a book will not have identical patterns. Two tickets have identical patterns if an only if they have the same symbol in the same positions.

C. Game 1 BLACKJACK: ACE symbol is 11 points.

D. Game 1 BLACKJACK: JACK, QUEEN, and KING are 10 points each.

E. Game 1 BLACKJACK: Each PLAYER'S HAND total will not match the DEALER'S HAND total to avoid ties.

F. Game 1 BLACKJACK: Non-winning prize symbols will not match winning prize symbols.

G. Game 1 BLACKJACK: All non-winning YOUR HAND total will be five (5) or less away from the DEALER'S HAND total.

H. Game 2 SLOTS: The will be no more than two (2) identical non-winning symbols combined in all spins.

I. Game 2 SLOTS: Non-winning spins will be unique. No two spins will have the same symbol in the same positions.

J. Game 2 SLOTS: Play symbol in non-winning spins will not match play symbols in winning spins.

K. Game 3 HIGH CARD: The lowest play symbol two (DEUCE) will never appear as a YOUR CARD symbol.

L. Game 3 HIGH CARD: The highest play symbol ACE will never appear as a DEALER'S CARD symbol.

M. Game 3 HIGH CARD: Ace is high.

N. Game 3 HIGH CARD: Each YOUR CARD hand will not match the corresponding DEALER'S CARD hand to avoid ties.

O. Game 3 HIGH CARD: Non-winning prize symbols will not match winning prize symbols.

P. Game 4 SNAKE EYES: There will be no more than three (3) identical play symbols in the game.

Q. Game 4 SNAKE EYES: There will be no more than two (2) identical non-winning roll totals.

R. Game 4 SNAKE EYES: A winning total is defined as the value of 7 or 11.

S. Game 4 SNAKE EYES: On games that win with SNAKE-EYES, SNAKE-EYES will only appear on one of the rolls. All other rolls will be non-winning.

T. Game 5 ROULETTE: There will be no more than two (2) identical non-winning prize symbols.

U. Game 5 ROULETTE: Non-winning prize symbols will not match winning prize symbols.

V. Game 6 BONUS PLAY: The lowest play symbol two (DEUCE) will never appear as the YOUR HAND symbol.

W. Game 6 BONUS PLAY: The highest play symbol ACE will never appear as the DEALER'S HAND symbol.

X. Game 6 BONUS PLAY: ACE symbol is high.

2.3 Procedure for Claiming Prizes.

A. To claim a "PLAYER'S CLUB" Instant Game prize of $10.00, $15.00, $20.00, $50.00, $100, $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00, $100, or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "PLAYER'S CLUB" Instant Game prize of $1,000, $10,000, or $250,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of

the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "PLAYER'S CLUB" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resource Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "PLAYER'S CLUB" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "PLAYER'S CLUB" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 4,080,000 tickets in the Instant Game No. 492. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 441 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$10	680,000	6.00
$15	380,800	10.71
$20	244, 800	16.67
$50	83,400	48.92
$100	16,500	247.27
$500	5,400	755.56
$1,000	540	7,555.56
$10,000	70	58,285.71
$250,000	4	1,020,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 2.89. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 492 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 492, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405254
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Instant Game Number 485 "Money Train"

1.0 Name and Style of Game.

A. The name of Instant Game No. 485 is "MONEY TRAIN". The play style is "key number match with auto win".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 485 shall be $1.00 per ticket.

1.2 Definitions in Instant Game No. 485.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, DOLLAR BILL SYMBOL, $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, $100, $500 and $2,000.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 485 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
DOLLAR BILL SYMBOL	AUTO
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUND
$500	FIV HUND
$2,000	TWO THOU

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 485 - 1.2E

CODE	PRIZE
ONE	$1.00
TWO	$2.00
FOR	$4.00
FIV	$5.00
TEN	$10.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the

bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $1.00, $2.00, $4.00, $5.00, $10.00 and $20.00.

H. Mid-Tier Prize - A prize of $50.00, $100 and $500.

I. High-Tier Prize - A prize of $2,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (485), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 249 within each pack. The format will be: 485-0000001-000.

L. Pack - A pack of "MONEY TRAIN" Instant Game tickets contains 250 tickets, packed in plastic shrink-wrapping and fanfolded in pages of five (5). Tickets 000 to 004 will be on the top page; tickets 005 to 009 on the next page; etc.; and tickets 245 to 249 will be on the last page. Tickets 000 and 249 will be manually folded over so some ticket fronts appear on each side of the book.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "MONEY TRAIN" Instant Game No. 485 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "MONEY TRAIN" Instant Game is determined once the latex on the ticket is scratched off to expose 12 (twelve) Play Symbols. If the player matches any of Your Numbers to either of the Winning Numbers, the player will win prize indicated for that number. If the player reveals a DOLLAR BILL SYMBOL, the player will win the prize indicated automatically. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 12 (twelve) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 12 (twelve) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 12 (twelve) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 12 (twelve) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets will not have identical play data, spot for spot.

B. No duplicate non-winning prize symbols on a ticket.

C. No duplicate non-winning Your Numbers on a ticket.

D. No duplicate Winning Numbers on a ticket.

E. Non-winning prize symbols will never be the same as the winning prize symbol(s).

F. No prize amount in a non-winning spot will correspond with the Your Number play symbol (i.e. 5 and $5).

G. The "dollar bill" symbol will only appear once on a ticket.

2.3 Procedure for Claiming Prizes.

A. To claim a "MONEY TRAIN" Instant Game prize of $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, $100, or $500 a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00, $100 or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "MONEY TRAIN" Instant Game prize of $2,000 the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "MONEY TRAIN" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resource Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "MONEY TRAIN" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.7 Disclaimer. The number of actual prizes in a game may vary based on sales, distribution, testing, and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated therefore, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated therefore, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated therefore. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 12,000,000 tickets in the Instant Game No. 485. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 485 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$1	1,392,000	8.62
$2	720,000	16.67
$4	144,000	83.33
$5	96,000	125.00
$10	72,000	166.67
$20	60,000	200.00
$50	13,750	872.73
$100	6,000	2,000.00
$500	40	300,000.00
$2,000	40	300,000.00

*The number of actual prizes may vary based on sales, distribution, testing, and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.79. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 485 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 485, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405242
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

♦ ♦ ♦

Instant Game Number 494 "Cash Craze"

1.0 Name and Style of Game.

A. The name of Instant Game No. 494 is "CASH CRAZE". The play style is "match up".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 494 shall be $1.00 per ticket.

1.2 Definitions in Instant Game No. 494.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $40.00, $50.00, $100, $500, and $2,000.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 494 - 1.2D

PLAY SYMBOL	CAPTION
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$40.00	FORTY
$50.00	FIFTY
$100	ONE HUND
$500	FIV HUND
$2,000	TWO THOU

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 494 - 1.2E

CODE	PRIZE
ONE	$1.00
TWO	$2.00
FOR	$4.00
FIV	$5.00
TEN	$10.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $1.00, $2.00, $4.00, $5.00, $10.00, or $20.00.

H. Mid-Tier Prize - A prize of $40.00, $50.00, $100, or $500.

I. High-Tier Prize - A prize of $2,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (494), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 249 within each pack. The format will be: 494-0000001-000.

L. Pack - A pack of "CASH CRAZE" Instant Game tickets contains 250 tickets, packed in plastic shrink-wrapping and fanfolded in pages of five (5). Tickets 000 to 004 will be on the top page; tickets 005 to 009 on the next page etc.; and tickets 245 to 249 will be on the last page. A ticket will be folded over on both the front and back of the book so both ticket art and ticket backs are displayed in the shrink-wrap.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "CASH CRAZE" Instant Game No. 494 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "CASH CRAZE" Instant Game is determined once

the latex on the ticket is scratched off to expose 6 (six) Play Symbols. If a player matches three amounts, the player will win that amount. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 6 (six) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 6 (six) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 6 (six) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 6 (six) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. No adjacent non-winning tickets will contain identical play symbols in the same locations.

B. No ticket will contain 4 or more of a kind.

C. No ticket will contain 3 pairs.

D. There will be a predominance of $20 and higher play symbols on non-winning tickets.

2.3 Procedure for Claiming Prizes.

A. To claim a "CASH CRAZE" Instant Game prize of $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $40.00, $50.00, $100, or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $40.00, $50.00, $100 or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "CASH CRAZE" Instant Game prize of $2,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "CASH CRAZE" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "CASH CRAZE" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "CASH CRAZE" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 14,160,000 tickets in the Instant Game No. 494. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 494 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$1	1,246,080	11.36
$2	1,076,160	13.16
$4	481,440	29.41
$5	113,280	125.00
$10	56,640	250.00
$20	28,320	500.00
$40	7,375	1,920.00
$50	4,130	3,428.57
$100	2,537	5,581.40
$500	708	20,000.00
$2,000	177	80,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.69. The individual odds of winning for a particular prize level may vary based on sales, distribution, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 494 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 494, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405246
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Instant Game Number 496 "Mega Slots"

1.0 Name and Style of Game.

A. The name of Instant Game No. 496 is "MEGA SLOTS". The play style is "key symbol match with auto win".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 496 shall be $5.00 per ticket.

1.2 Definitions in Instant Game No. 496.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $1.00, $2.00, $3.00, $5.00, $10.00, $20.00, $50.00, $100, $200, $1,000, $5,000, $50,000, SEVEN SYMBOL, BAR SYMBOL, MONEY SIGN SYMBOL, HORSESHOE SYMBOL, LEMON SYMBOL, BANANA SYMBOL, GOLD SYMBOL, MELON SYMBOL, CHERRY SYMBOL, APPLE SYMBOL, GRAPE SYMBOL, BELL SYMBOL, PLUM SYMBOL, CROWN SYMBOL, DIAMOND SYMBOL, STAR SYMBOL, COIN SYMBOL, STACK OF BILLS SYMBOL, and WIN SYMBOL.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 496 - 1.2D

PLAY SYMBOL	CAPTION
$1.00	ONE$
$2.00	TWO$
$3.00	THREE$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUND
$200	TWO HUND
$1,000	ONE THOU
$5,000	FIV THOU
$50,000	50 THOU
SEVEN SYMBOL	SEVN
BAR SYMBOL	BARR
DOLLAR SIGN SYMBOL	MONY
HORSESHOE SYMBOL	SHOE
LEMON SYMBOL	LEMN
BANANA SYMBOL	BNNA
GOLD SYMBOL	GOLD
MELON SYMBOL	MELN
CHERRY SYMBOL	CHRY
APPLE SYMBOL	APPL
GRAPE SYMBOL	GRPE
BELL SYMBOL	BELL
PLUM SYMBOL	PLUM
CROWN SYMBOL	CRWN
DIAMOND SYMBOL	DMND
STAR SYMBOL	STAR
COIN SYMBOL	COIN
STACK OF BILLS SYMBOL	DLRS
WIN SYMBOL	WIN

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 496 - 1.2E

CODE	PRIZE
FIV	$5.00
TEN	$10.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $5.00, $10.00, or $20.00.

H. Mid-Tier Prize - A prize of $50.00, $100, $200, or $500.

I. High-Tier Prize - A prize of $1,000, $5,000 or $50,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (496), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 74 within each pack. The format will be: 496-0000001-000.

L. Pack - A pack of "MEGA SLOTS" Instant Game tickets contains 75 tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The packs will alternate. One will show the front of ticket 000 and back of 074 while the other fold will show the back of ticket 000 and front of 074.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "MEGA SLOTS" Instant Game No. 496 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "MEGA SLOTS" Instant Game is determined once the latex on the ticket is scratched off to expose eighty (80) Play Symbols. If a player matches three symbols in any one game, the player will win the prize shown for that game. If the player gets a win symbol, the player will win the prize for that game instantly. If the player gets a fire symbol, the player will win the prize shown instantly. If the player gets a chili pepper symbol, the player will win triple the prize shown. No portion of the display printing or any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly eighty (80) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly eighty (80) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the eighty (80) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the eighty (80) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the

Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets will not have identical play data, spot for spot.

B. No four or more like non-winning prize symbols on a ticket.

C. There will be many "near wins" on a ticket.

D. No duplicate non-winning games in the exact same order will be adjacent to each other on a ticket.

2.3 Procedure for Claiming Prizes.

A. To claim a "MEGA SLOTS" Instant Game prize of $5.00, $10.00, $20.00, $50.00, $100, $200, or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00, $100, $200, or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "MEGA SLOTS" Instant Game prize of $1,000, $5,000, or $50,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "MEGA SLOTS" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "MEGA SLOTS" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "MEGA SLOTS" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 5,040,000 tickets in the Instant Game No. 496. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 496 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$5	1,276,800	3.95
$10	100,800	50.00
$20	67,200	75.00
$50	67,200	75.00
$100	27,720	181.82
$200	2,520	2,000.00
$500	1,848	2,727.27
$1,000	55	91,636.36
$5,000	35	144,000.00
$5,000	12	420,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.26. The individual odds of winning for a particular prize level may vary based on sales, distribution, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 496 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 496, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405248
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Instant Game Number 497 "Texas Winnings"

1.0 Name and Style of Game.

A. The name of Instant Game No. 497 is "TEXAS WINNINGS". The play style is "key number match with multiplier".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 497 shall be $2.00 per ticket.

1.2 Definitions in Instant Game No. 497.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, $200, $1,000, $25,000, 1 SYMBOL, 2 SYMBOL, 3 SYMBOL, 4 SYMBOL, 5 SYMBOL, 6 SYMBOL, 7 SYMBOL, 8 SYMBOL, 9 SYMBOL, 10 SYMBOL, 11 SYMBOL, 12 SYMBOL, 13 SYMBOL, 14 SYMBOL, 15 SYMBOL, 16 SYMBOL, 17 SYMBOL, 18 SYMBOL, 19 SYMBOL, 20 SYMBOL, 21 SYMBOL, 22 SYMBOL, 23 SYMBOL, 24 SYMBOL, and JACKPOT SYMBOL.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 497 - 1.2D

PLAY SYMBOL	CAPTION
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$200	TWO HUND
$1,000	ONE THOU
$25,000	25 THOU
1 SYMBOL	ONE
2 SYMBOL	TWO
3 SYMBOL	THR
4 SYMBOL	FOR
5 SYMBOL	FIV
6 SYMBOL	SIX
7 SYMBOL	SVN
8 SYMBOL	EGT
9 SYMBOL	NIN
10 SYMBOL	TEN
11 SYMBOL	ELV
12 SYMBOL	TLV
13 SYMBOL	TRN
14 SYMBOL	FTN
15 SYMBOL	FFN
16 SYMBOL	SXN
17 SYMBOL	SVT
18 SYMBOL	ETN
19 SYMBOL	NTN
20 SYMBOL	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
JACKPOT SYMBOL	WINX5

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 497 - 1.2E

CODE	PRIZE
TWO	$2.00
FIV	$5.00
EGT	$8.00
TEN	$10.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $2.00, $5.00, $8.00, $10.00, or $20.00.

H. Mid-Tier Prize - A prize of $50.00, or $200.

I. High-Tier Prize - A prize of $1,000 or $25,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (497), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 249 within each pack. The format will be: 497-0000001-000.

L. Pack - A pack of "TEXAS WINNINGS" Instant Game tickets contains 250 tickets, packed in plastic shrink-wrapping and fanfolded in pages of two (2). Tickets 000 and 001 are on the top page, tickets 002 and 003 are on the next page, and so forth, and tickets 248 and 249 on the last page. Please note the books will be in an A - B configuration.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "TEXAS WINNINGS" Instant Game No. 497 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "TEXAS WINNINGS" Instant Game is determined once the latex on the ticket is scratched off to expose twenty-two (22) Play Symbols. If a player matches any of YOUR COINS to either LUCKY COIN, the player will win the prize shown for that coin. If the player gets a jackpot symbol, the player will win five times the prize shown instantly. No portion of the display printing or any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly twenty-two (22) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly twenty-two (22) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the twenty-two (22) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the twenty-two (22) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets will not have identical "spot for spot" play data.

B. No duplicate non-winning Your Coins play symbols on a ticket.

C. No duplicate Lucky Coins play symbols on a ticket.

D. No three of more like non-winning prize symbols on a ticket.

E. No more than one pair of duplicate non-winning prize symbols on a ticket.

F. The jackpot symbol will never appear more than once on a ticket.

G. Non-winning prize symbols will never be the same as the winning prize symbol(s).

H. No prize amount in a non-winning spot will correspond with the Your Coins play symbol (i.e. 5 and $5).

2.3 Procedure for Claiming Prizes.

A. To claim a "TEXAS WINNINGS" Instant Game prize of $2.00, $5.00, $8.00, $10.00, $20.00, $50.00, or $200, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00 or $200 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "TEXAS WINNINGS" Instant Game prize of $1,000 or $25,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "TEXAS WINNINGS" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "TEXAS WINNINGS" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "TEXAS WINNINGS" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 10,080,000 tickets in the Instant Game No. 497. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 497 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$2	1,249,920	8.06
$5	604,800	16.67
$8	181,440	55.56
$10	80,640	125.00
$20	60,480	166.67
$50	40,320	250.00
$200	8,568	1176.47
$1,000	130	77,538.46
$25,000	10	1,008,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.53. The individual odds of winning for a particular prize level may vary based on sales, distribution, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 497 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 497, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405244
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Instant Game Number 498 "Spicy 8's"

1.0 Name and Style of Game.

A. The name of Instant Game No. 498 is "SPICY 8'S". The play style is "three in a line with auto win".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 498 shall be $1.00 per ticket.

1.2 Definitions in Instant Game No. 498.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $1.00, $2.00,

$3.00, $5.00, $8.00, $10.00, $50.00, $100, $800, 2 SYMBOL, 3 SYMBOL, 4 SYMBOL, 5 SYMBOL, 6 SYMBOL, 7 SYMBOL, 8 SYMBOL, 9 SYMBOL, NO BONUS SYMBOL, TRY AGAIN SYMBOL, and WILD SYMBOL.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 498 - 1.2D

PLAY SYMBOL	CAPTION
$1.00	ONE$
$2.00	TWO$
$3.00	THREE$
$5.00	FIVE$
$8.00	EIGHTS
$10.00	TEN$
$50.00	FIFTY
$100	ONE HUND
$800	EGT HUND
2 SYMBOL	
3 SYMBOL	
4 SYMBOL	
5 SYMBOL	
6 SYMBOL	
7 SYMBOL	
8 SYMBOL	
9 SYMBOL	
NO BONUS	NO BONUS
TRY AGAIN	TRY AGAIN
WILD	WIN $10

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 498 - 1.2E

CODE	PRIZE
ONE	$1.00
TWO	$2.00
THR	$3.00
FIV	$5.00
EGT	$8.00
TEN	$10.00
TWL	$12.00
TRT	$13.00
FTN	$15.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $1.00, $2.00, $3.00, $5.00, $8.00, $10.00,$12.00, $13.00, $15.00, or $20.00.

H. Mid-Tier Prize - A prize of $50.00, or $100.

I. High-Tier Prize - A prize of $800.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (498), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 249 within each pack. The format will be: 498-0000001-000.

L. Pack - A pack of "SPICY 8'S" Instant Game tickets contains 250 tickets, packed in plastic shrink-wrapping and fanfolded in pages of five (5). Ticket 000 to 004 will be on the top page; tickets 005 to 009 on the next page etc.; and tickets 245 to 249 will be on the last page. A ticket will be folded over on both the front and back of the book so both ticket art and ticket backs are displayed in the shrink-wrap.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "SPICY 8'S" Instant Game No. 498 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "SPICY 8'S" Instant Game is determined once the latex on the ticket is scratched off to expose eleven (11) Play Symbols. If a player gets three 8 symbols in any one row, column or diagonal, the player will win the prize in the prize box. If the player gets a wild symbol under the bonus box, the player will win $10 instantly. No portion of the display printing or any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly eleven (11) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly eleven (11) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the eleven (11) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the eleven (11) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. No adjacent non-winning tickets will contain identical play symbols, in the same locations.

B. Every ticket will contain at leas four 8's. The overall usage for the remaining play symbols will be approximately even.

2.3 Procedure for Claiming Prizes.

A. To claim a "SPICY 8'S" Instant Game prize of $1.00, $2.00, $3.00, $5.00, $8.00, $10.00, $12.00, $13.00, $15.00, $20.00, $50.00, or $100, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00 or $100 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "SPICY 8'S" Instant Game prize of $800, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "SPICY 8'S" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "SPICY 8'S" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "SPICY 8'S" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 15,120,000 tickets in the Instant Game No. 498. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 498 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$1	1,391,040	10.87
$2	907,200	16.67
$3	604,800	25.00
$5	120,960	125.00
$8	30,240	500.00
$10	30,240	500.00
$12	30,240	500.00
$13	30,240	500.00
$15	30,240	500.00
$20	30,240	500.00
$50	12,096	1,250.00
$100	2,772	5,454.55
$800	252	60,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.69. The individual odds of winning for a particular prize level may vary based on sales, distribution, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 498 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 498, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405243
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Instant Game Number 508 "Joker's Wild"

1.0 Name and Style of Game.

A. The name of Instant Game No. 508 is "JOKER'S WILD". The play style is "cards".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 508 shall be $1.00 per ticket.

1.2 Definitions in Instant Game No. 508.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $1.00, $2.00, $4.00, $10.00, $20.00, $50.00, $100, $300, $2,100, 2 DIAMONDS SYMBOL, 3 DIAMONDS SYMBOL, 4 DIAMONDS SYMBOL, 5 DIAMONDS SYMBOL, 6 DIAMONDS SYMBOL, 7 DIAMONDS SYMBOL, 8 DIAMONDS SYMBOL, 9 DIAMONDS SYMBOL, 10 DIAMONDS SYMBOL, J DIAMONDS SYMBOL, Q DIAMONDS SYMBOL, K DIAMONDS SYMBOL, A DIAMONDS SYMBOL, 2 CLUBS SYMBOL, 3 CLUBS SYMBOL, 4 CLUBS SYMBOL, 5 CLUBS SYMBOL, 6 CLUBS SYMBOL, 7 CLUBS SYMBOL, 8 CLUBS SYMBOL, 9 CLUBS SYMBOL, 10 CLUBS SYMBOL, J CLUBS SYMBOL, Q CLUBS SYMBOL, K CLUBS SYMBOL, A CLUBS SYMBOL, 2 HEARTS SYMBOL, 3 HEARTS SYMBOL, 4 HEARTS SYMBOL, 5 HEARTS SYMBOL, 6 HEARTS SYMBOL, 7 HEARTS SYMBOL, 8 HEARTS SYMBOL, 9 HEARTS SYMBOL, 10 HEARTS SYMBOL, J HEARTS SYMBOL, Q HEARTS SYMBOL, K HEARTS SYMBOL, A HEARTS SYMBOL, 2 SPADES SYMBOL, 3 SPADES SYMBOL, 4 SPADES SYMBOL, 5 SPADES SYMBOL, 6 SPADES SYMBOL, 7 SPADES SYMBOL, 8 SPADES SYMBOL, 9 SPADES SYMBOL, 10 SPADES SYMBOL, J SPADES SYMBOL, Q SPADES SYMBOL, K SPADES SYMBOL, A SPADES SYMBOL, and JOKER'S HAT SYMBOL.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 508 - 1.2D

PLAY SYMBOL	CAPTION
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUN
$300	THR HUN
$2,100	21 HUN
2 CLUBS CARD SYMBOL	twoc
3 CLUBS CARD SYMBOL	threec
4 CLUBS CARD SYMBOL	fourc
5 CLUBS CARD SYMBOL	fivec
6 CLUBS CARD SYMBOL	sixc
7 CLUBS CARD SYMBOL	sevenc
8 CLUBS CARD SYMBOL	eightc
9 CLUBS CARD SYMBOL	ninec
10 CLUBS CARD SYMBOL	tenc
J CLUBS CARD SYMBOL	jackc
Q CLUBS CARD SYMBOL	queenc
K CLUBS CARD SYMBOL	kingc
A CLUBS CARD SYMBOL	acec
2 SPADES CARD SYMBOL	twos
3 SPADES CARD SYMBOL	threes
4 SPADES CARD SYMBOL	fours
5 SPADES CARD SYMBOL	fives
6 SPADES CARD SYMBOL	sixs
7 SPADES CARD SYMBOL	sevens
8 SPADES CARD SYMBOL	eights
9 SPADES CARD SYMBOL	nines
10 SPADES CARD SYMBOL	tens
J SPADES CARD SYMBOL	jacks
Q SPADES CARD SYMBOL	queens
K SPADES CARD SYMBOL	kings
A SPADES CARD SYMBOL	aces
2 HEARTS CARD SYMBOL	twoh
3 HEARTS CARD SYMBOL	threeh
4 HEARTS CARD SYMBOL	fourh
5 HEARTS CARD SYMBOL	fiveh
6 HEARTS CARD SYMBOL	sixh
7 HEARTS CARD SYMBOL	sevenh
8 HEARTS CARD SYMBOL	eighth
9 HEARTS CARD SYMBOL	nineh
10 HEARTS CARD SYMBOL	tenh
J HEARTS CARD SYMBOL	jackh
Q HEARTS CARD SYMBOL	queenh

K HEARTS CARD SYMBOL	kingh
A HEARTS CARD SYMBOL	acesh
2 DIAMONDS CARD SYMBOL	twod
3 DIAMONDS CARD SYMBOL	threed
4 DIAMONDS CARD SYMBOL	fourd
5 DIAMONDS CARD SYMBOL	fived
6 DIAMONDS CARD SYMBOL	sixd
7 DIAMONDS CARD SYMBOL	sevend
8 DIAMONDS CARD SYMBOL	eighthd
9 DIAMONDS CARD SYMBOL	nined
10 DIAMONDS CARD SYMBOL	tend
J DIAMONDS CARD SYMBOL	jackd
Q DIAMONDS CARD SYMBOL	queend
K DIAMONDS CARD SYMBOL	kingd
A DIAMONDS CARD SYMBOL	aced

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 508 - 1.2E

CODE	PRIZE
ONE	$1.00
TWO	$2.00
FOR	$4.00
TEN	$10.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $1.00, $2.00, $4.00, $10.00 or $20.00.

H. Mid-Tier Prize - A prize of $50.00, $100 or $300.

I. High-Tier Prize - A prize of $2,100.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (508), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 249 within each pack. The format will be: 508-0000001-000.

L. Pack - A pack of "JOKER'S WILD" Instant Game tickets contains 250 tickets, packed in plastic shrink-wrapping and fanfolded in pages of five (5). Ticket 000 to 004 will be on the top page; tickets 005 to 009 on the next page etc.; and tickets 245 to 249 will be on the last page. Tickets 000 and 249 will be folded down to expose the pack-ticket number through the shrink-wrap.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "JOKER'S WILD" Instant Game No. 508 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "JOKER'S WILD" Instant Game is determined once the latex on the ticket is scratched off to expose 18 (eighteen) Play Symbols. If a player reveals three (3) identical play symbols the player

wins prize indicated for that Hand. If a player reveals two (2) identical play symbols and a Joker's Hat the player wins prize indicated for that Hand. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 18 (eighteen) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 18 (eighteen) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 18 (eighteen) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 18 (eighteen) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets within a book will not have identical patterns.

B. Players can win up to three (3) times on this ticket.

C. No ticket will contain more than two (2) like PRIZE amounts, except in the case of multiple wins.

D. There will never be 3 identical cards or 2 identical cards and "Joker" symbol appearing in the same column.

E. A maximum of one (1) "Joker" symbol will appear per HAND.

F. The same card symbol (value & suit) will never appear more than once on a single ticket with the exception of the "Joker" symbol.

G. Winning and non-winning HANDS will be different from each other.

H. Wins with 2 identical cards plus the "Joker" symbol will never have an additional pair in the winning HAND.

I. On winning hands, there will never be a "Joker" symbol in addition to three identical card symbols.

J. No non-winning ticket will contain three (3) like PRIZE amounts.

2.3 Procedure for Claiming Prizes.

A. To claim a "JOKER'S WILD" Instant Game prize of $1.00, $2.00, $4.00, $10.00, $20.00, $50.00, $100 or $300, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00, $100 or $300 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "JOKER'S WILD" Instant Game prize of $2,100, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the

event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "JOKER'S WILD" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "JOKER'S WILD" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "JOKER'S WILD" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 13,920,000 tickets in the Instant Game No. 508. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 508 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$1	1,586,880	8.77
$2	779,520	17.86
$4	306,240	45.45
$10	125,280	111.11
$20	41,760	333.33
$50	14,848	937.50
$100	5,336	2,608.70
$300	1,508	9,230.77
$2,100	78	178,461.54

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.86. The individual odds of winning for a particular prize level may vary based on sales, distribution, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 508 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 508, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405249
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Instant Game Number 509 "Super 6's"

1.0 Name and Style of Game.

A. The name of Instant Game No. 509 is "SUPER 6'S". The play style is "three in a line with doubler".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 509 shall be $2.00 per ticket.

1.2 Definitions in Instant Game No. 509.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $1.00, $2.00, $4.00, $8.00, $10.00, $20.00, $50.00, $100, $200, $2,000, $26,000, X SYMBOL, O SYMBOL, 6 SYMBOL, TRY SYMBOL, and NEXT SYMBOL.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 509 - 1.2D

PLAY SYMBOL	CAPTION
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$8.00	EIGHT$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUND
$200	TWO HUND
$2,000	TWO THOU
$26,000	26 THOU

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 509 - 1.2E

CODE	PRIZE
TWO	$2.00
FOR	$4.00
EGT	$8.00
TEN	$10.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $2.00, $4.00, $8.00, $10.00 or $20.00.

H. Mid-Tier Prize - A prize of $50.00, $100 or $200.

I. High-Tier Prize - A prize of $2,000 or $26,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (509), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 249 within each pack. The format will be: 509-0000001-000.

L. Pack - A pack of "SUPER 6'S" Instant Game tickets contains 250 tickets, packed in plastic shrink-wrapping and fanfolded in pages of two (2). Ticket 000 and 001 will be shown on the front of the pack; the backs of ticket 248 and 249 will show. Every other book will be opposite. All packs will be tightly shrink-wrapped. There will be no breaks between tickets in a pack.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "SUPER 6'S" Instant Game No. 509 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "SUPER 6'S" Instant Game is determined once the latex on the ticket is scratched off to expose 20 (twenty) Play Symbols. If a player reveals three Xs or Os play symbols either diagonally, vertically or horizontally the player wins prize indicated for that play area. If a player reveals a "6" Super Six Symbol in either tic tac toe game the player wins double the prize for that game automatically. In the Bonus Play Area, if the player finds an amount, the player will win

that amount instantly. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 20 (twenty) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 20 (twenty) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 20 (twenty) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 20 (twenty) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets within a book will not have identical patterns. Players can win up to three (3) times.

B. In each Tic Tac Toe play area, the play symbols and prize symbol will be used randomly and evenly across all nine (9) Play symbol positions and one (1) Prize symbol position for both winning and non-winning tickets, with respect to other restrictions.

C. Tickets that win with the "Super 6" play symbol, will win as per the prize structure.

D. Each Tic Tac Toe play area will contain four (4) or five (5) "X" symbols and four (4) or five (5) "O" symbols, with the exception of tickets that win with the "Super 6" play symbol.

E. Winning tickets can only win by getting either three (3) "X" symbols in the same row, column, or diagonal or by getting three (3) "O" symbols in the same row, column or diagonal or finding a "Super 6" play symbol in any row, column or diagonal, or finding a Prize Amount in the Bonus Area, with respect to other restrictions.

F. Non-winning tickets will never have four (4) "X" symbols in all four (4) corners nor four (4) "O" symbols in all four (4) corners in one Tic Tac Toe play area.

G. Non-winning tickets will never have a "Super 6" play symbol.

H. Approximately 50% of all non-winning tickets will have five (5) "X" symbols and four (4) "O" symbols and approximately 50 % will have four (4) "X" symbols and five (5) "O" symbols in each Tic Tac Toe play area.

I. Winning tickets will only contain the following prizes: $2, $4, $8, $10, $20, $50, $100 and $200.

J. Tickets that do not win in the Bonus Area will display one of the non-winning play symbols.

2.3 Procedure for Claiming Prizes.

A. To claim a "SUPER 6'S" Instant Game prize of $2.00, $4.00, $8.00, $10.00, $20.00, $50.00 $100 or $200, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00, $100 or $200 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly.

A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "SUPER 6'S" Instant Game prize of $2,000 or $26,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "SUPER 6'S" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "SUPER 6'S" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "SUPER 6'S" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 10,080,000 tickets in the Instant Game No. 509. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 509 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$2	1,048,320	9.62
$4	604,800	16.67
$8	322,560	31.25
$10	100,800	100.00
$20	50,400	200.00
$50	29,274	344.33
$100	11,760	857.14
$200	5,040	2,000.00
$2,000	80	126,000.00
$26,000	7	1,440,000

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.64. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 509 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 509, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405250
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Instant Game Number 510 "$100,000 Payout!"

1.0 Name and Style of Game.

A. The name of Instant Game No. 510 is "$100,000 PAYOUT!". The play style for Play Area 1 is "key number match with auto win". The play style for Play Area 2 is "three in a line". The play style for Play Area 3 is "match up". The play style for Play Area 4 is "key symbol match with prize legend". The play style for Play Area 5 is "add up".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 510 shall be $5.00 per ticket.

1.2 Definitions in Instant Game No. 510.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: $5.00, $10.00, $15.00, $20.00, $50.00, $100, $500, $5,000, $100,000, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, HORSESHOE SYMBOL, DIAMOND SYMBOL, COIN SYMBOL, STACK OF BILLS SYMBOL, SAFE SYMBOL, GOLD NUGGET SYMBOL, CROWN SYMBOL, GOLD BAR SYMBOL, BELL SYMBOL, DOLLAR SIGN SYMBOL, CLOVER LEAF SYMBOL, CHERRY SYMBOL, ONE DICE SYMBOL, TWO DICE SYMBOL, THREE DICE SYMBOL, FOUR DICE SYMBOL, FIVE DICE SYMBOL and SIX DICE SYMBOL.

D. Play Symbol Caption - the printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 510 - 1.2D

PLAY SYMBOL	CAPTION
$5.00	FIVE$
$10.00	TEN$
$15.00	FIFTEEN
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUN
$500	FIV HUN
$5,000	FIV THOU
$100,000	100 THOU
01	ONE
02	TWO
03	THR
04	FOR
05	FIV
06	SIX
07	SVN
08	EGT
09	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FON
15	FTN
16	SXT
17	SVT
18	EGN
19	NTN
20	TWY
HORSE SHOE SYMBOL	HSHOE
DIAMOND SYMBOL	DIAMOND
COIN SYMBOL	COIN
STACK OF BILLS SYMBOL	BILLS
SAFE SYMBOL	SAFE
GOLD NUGGET SYMBOL	NUGGET
CROWN SYMBOL	CROWN
GOLD BAR SYBMOL	GOLD
BELL SYMBOL	BELL
DOLLAR SIGN SYMBOL	DOLLAR
CLOVER LEAF SYMBOL	CLOVER
CHERRY SYMBOL	CHERRY
ONE DICE SYMBOL	ONE
TWO DICE SYMBOL	TWO
THREE DICE SYMBOL	THR
FOUR DICE SYMBOL	FOR
FIVE DICE SYMBOL	FIV
SIX DICE SYMBOL	SIX

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 510 - 1.2E

CODE	PRIZE
FIV	$5.00
TEN	$10.00
FTN	$15.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $5.00, $10.00, $15.00, or $20.00.

H. Mid-Tier Prize - A prize of $50.00, $100 or $500.

I. High-Tier Prize - A prize of $5,000 or $100,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (510), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 074 within each pack. The format will be: 510-0000001-000.

L. Pack - A pack of "$100,000 PAYOUT!" Instant Game tickets contains 75 tickets, packed in plastic shrink-wrapping and fanfolded in pages of two (2). Tickets 000 and 001 will be on the top page; tickets 002 and 003 on the next page; etc.; and tickets 248 and 249 will be on the last page. Please note the books will be in an A - B configuration.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "$100,000 PAYOUT!" Instant Game No. 510 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "$100,000 PAYOUT!" Instant Game is determined once the latex on the ticket is scratched off to expose 50 (fifty) Play Symbols. In Play Area 1, if the player matches any of the YOUR NUMBERS play symbols to either of the WINNING NUMBERS play symbols, the player will win the prize shown for that number. If the player gets a horseshoe symbol, the player will win that prize automatically. In Play Area 2, if the player reveals three identical symbols, either diagonally, vertically or horizontally, the player will win the prize shown. In Play Area 3, if the player matches three amounts, the player will win that amount. In Play Area 4, if the player matches three symbols in any one spin, the player will win the prize shown in the legend below. In Play Area 5, if the dice in any one game add up to 7 or 11, the player will win the corresponding prize. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 50 (fifty) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 50 (fifty) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 50 (fifty) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 50 (fifty) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets within a book will not have identical patterns.

B. Play Area 1: Players can win up to seven (7) times in this play area.

C. Play Area 1: The two (2) "WINNING NUMBERS" on each ticket will always be different from each other.

D. Play Area 1: The "Horse shoe" symbol will never appear on non-winning tickets.

E. Play Area 1: The "Horse shoe" symbol will never appear as one of the "WINNING NUMBERS".

F. Play Area1: The "Horse shoe" symbol will never appear more than once on a ticket.

G. Play Area 2: Players can win once in this play area.

H. Play Area 2: Winning tickets will win having three (3) "Diamond", "Coin", "Stack of Bills", "Safe" or "Gold Nugget" symbols in any row, diagonal or column.

I. Play Area 2: Winning tickets will contain only one (1) winning combination.

J. Play Area 2: Winning and Non- winning tickets will not contain four (4) like Play Symbols in all four corners.

K Play Area 3: Players can win once in this play area.

L. Play Area 3: There will never be more than one (1) set of three (3) like prize amounts on a single ticket.

M. Play Area 4: There will never be more than three (3) like prize amounts on a single ticket.

N. Play Area 4: Players can win up to three (3) times in this area.

O. Play Area 4: There will be no duplicate non-winning spins in any order on a ticket

P. Play Area 4: There will never be three (3) identical Play Symbols in a vertical or diagonal line.

Q. Play Area 4: Non-winning tickets will never contain more than two (2) of the same PLAY SYMBOLS over the entire game play area.

R. Play Area 4: Consecutive non-winning tickets will not have identical games (e.g. If the first ticket shows Crown, Gold Bar, and Bell in any game then the next ticket may not contain Crown, Gold Bar, and Bell in that exact order in any game.).

S. Play Area 4: Winning tickets will win according to the prize legend on the front of the ticket: three (3) "Crowns" $100,000; three (3) "Gold Bars" $5,000; three (3) "Bells" $500; three (3) "Dollar Signs" $100; three (3) "4 Leaf Clovers" $50; three (3) "Cherries" $5.

T. Play Area 5: Players can win up to three (3) times in this area.

U. Play Area 5: There will be no relationship between the value of the dice total for any one game and the prize value, i.e. the dice total should not be unique to specific prizes.

V. Play Area 5: The Dice Value Play Symbols will range from 1 to 6 and will be used randomly and approximately evenly over all 6 dice positions with respect to other restrictions.

W. Play Area 5: Winning tickets will contain a random and even distribution of dice combinations totaling 7 or 11, with respect to other restrictions.

X. Play Area 5: The total value of each roll will never equal seven (7) or eleven (11) in any of GAME 1, GAME 2, and GAME 3 for non-winning tickets.

Y. Play Area 5: There will never be one (1) + one (1) (snake eyes) to avoid the appearance of eleven (11).

Z. Play Area 5: Non-winning tickets will never contain a dice combination with a sum total of 7 or 11 in any of GAMES 1 through 3.

AA. Play Area 5: The total value of the two dice in a roll when added together will not appear more than 2 times on any one ticket, except in the case of multiple winners.

BB. Play Area 5: The same Prize Amount will not appear more than two (2) times across GAMES 1 through 3, except in the case of multiple winners.

2.3 Procedure for Claiming Prizes.

A. To claim a "$100,000 PAYOUT!" Instant Game prize of $5.00, $10.00, $15.00, $20.00, $50.00, $100 or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00, $100 or $500

ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$100,000 PAYOUT!" Instant Game prize of $5,000 or $100,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$100,000 PAYOUT!" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "$100,000 PAYOUT!" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "$100,000 PAYOUT!" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 5,040,000 tickets in the Instant Game No. 510. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 510 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$5	638,400	7.89
$10	537,600	9.38
$15	168,000	30.00
$20	100,800	50.00
$50	25,200	200.00
$100	14,910	338.03
$500	1,638	3,076.92
$5,000	32	157,500.00
$100,000	3	1,680,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 3.39. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 510 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 510, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200405245
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: August 19, 2004

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Texas Department of Mental Health and Mental Retardation

Department of Aging and Disability Services HCS Pre-Application Orientation

Public Notice Announcing Pre-Application Orientation (PAO) for Enrollment of Medicaid Waiver Program Providers

The Department of Aging and Disability Services (DADS) will hold a Pre-Application Orientation (PAO) for persons seeking to participate as a program provider in the Home and Community-Based Services (HCS) Program.

The PAO will be held at 8:30 a.m., Monday, December 6, 2004, in Austin, Texas at the J. J. Pickle Center. Persons wanting to attend the PAO must request a registration form by mail or by fax. Mailed requests must be addressed to Bill Fordyce, Enrollment/Sanctions Manager, Provider Services Division, DADS, P.O. Box 12668, Austin, Texas 78711-2668. Faxed requests must be made to (512) 206-5725.

Upon an applicant's written request, DADS will provide the applicant with information regarding the provider application and enrollment processes and a registration form for the PAO. To attend the PAO, an applicant must submit a completed registration form to DADS in a timely manner. A completed registration form will be considered to have been submitted in a timely manner only under the following conditions: (1) if mailed via the US Postal Service, the completed registration form bears a postmark date no later than November 8, 2004; or (2) if sent via a common or contract carrier, a receipt by the carrier shows that it was placed in the hands of the carrier no later than November 8, 2004; (or) if hand delivered, it is delivered directly to the Office of Medicaid Administration, DADS, 909 West 45th Street, Building 4, Austin, Texas, no later than November 8, 2004.

Persons requiring an interpreter for the deaf or hearing impaired or other accommodation must contact Bill Fordyce by calling (512) 206-5718 or the TTY phone number of Texas Relay, which is 1-800-735-2988, at least 72 hours prior to the PAO. Bill Fordyce may also be contacted for any other information concerning the PAO.

TRD-200405372
Rudy Arredondo
Chairman, Texas Board of MHMR
Texas Department of Mental Health and Mental Retardation
Filed: August 25, 2004

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North Central Texas Council of Governments

Consultant Proposal Request

This request by the North Central Texas Council of Governments (NCTCOG) for consultant services is filed under the provisions of Government Code, Chapter 2254.

NCTCOG is seeking written proposals from consultants to conduct a Bus and Paratransit Study for the Denton County Transportation Authority (DCTA). It is anticipated that the project may require engineering services. The project will be funded through the 2003-2004 and 2004-2005 Unified Planning Work Programs (UPWP). The consultant effort will be a study of the implementation of regional express bus service, local bus service enhancements in Denton and Lewisville, and examination of the current paratransit service throughout the cities of Denton, Highland Village, and Lewisville. Data will be collected to analyze existing service and to plan future levels of bus service. This analysis coupled with a review of the 2003 DCTA Service Plan recommendations will be used to develop recommendations for potential regional express bus, local bus, and paratransit services.

Due Date

Proposals must be submitted no later than 5 p.m. Central Daylight Time on Friday, October 8, 2004, to Christie Zupancic, Senior Transportation Planner, North Central Texas Council of Governments, 616 Six Flags Drive, Arlington, Texas 76011 or P.O. Box 5888, Arlington, Texas 76005-5888. For copies of the Request for Proposals, contact Angela Carson, (817) 695-9240.

Contract Award Procedures

The firm or individual selected to perform this study will be recommended by a Project Review Committee. The PRC will use evaluation criteria and methodology consistent with the scope of services contained in the Request for Proposals. The NCTCOG Executive Board will review the PRC's recommendations and, if found acceptable, will issue a contract award.

Regulations

NCTCOG, in accordance with Title VI of the Civil Rights Act of 1964, 78 Statute 252, 41 United States Code 2000d to 2000d-4; and Title 49, Code of Federal Regulations, Department of Transportation, Subtitle A, Office of the Secretary, Part 1, Nondiscrimination in Federally Assisted Programs of the Department of Transportation issued pursuant to such act, hereby notifies all proposers that it will affirmatively assure that in regard to any contract entered into pursuant to this advertisement, disadvantaged business enterprises will be afforded full opportunity to submit proposals in response to this invitation and will not be discriminated against on the grounds of race, color, sex, age, national origin, or disability in consideration of an award.

TRD-200405234
R. Michael Eastland
Executive Director
North Central Texas Council of Governments
Filed: August 18, 2004

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Texas State Board of Pharmacy

Election of Officers

The Texas State Board of Pharmacy announces the election of the following officers to serve from September 1, 2004 to August 31, 2005: Oren M. Peacock, Jr., R.Ph., President; W. Michael Brimberry, R.Ph., MBA, Vice President; Kim A. Caldwell, R.Ph., Treasurer.

TRD-200405298
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Filed: August 23, 2004

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Public Utility Commission of Texas

Notice of Application for Amendment to Service Provider Certificate of Operating Authority

On August 13, 2004, BellSouth BSE, Incorporated filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60172. Applicant intends to reflect a change in ownership/control and a name change.

The Application: Application of BellSouth BSE, Incorporated for an Amendment to its Service Provider Certificate of Operating Authority, Docket Number 30082.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas, 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than September 8, 2004. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30082.

TRD-200405338
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 23, 2004

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Notice of Application for Waiver of Denial of Request for NXX Code

Notice is given to the public of the filing with the Public Utility Commission of Texas an application on August 16, 2004, for waiver of denial by the North American Numbering Plan Administrator (NANPA) Pooling Administrator (PA) of Southwestern Bell Telephone, L.P.'s, doing business as SBC Texas, request for NXX codes.

Docket Title and Number: Application of Southwestern Bell Telephone, L.P., doing business as SBC Texas, for Waiver of NeuStar, Incorporated Denial of NXX Code Request. Docket Number 30089.

The Application: Southwestern Bell Telephone, L.P., doing business as SBC Texas (SBC Texas), submitted a Central Office Code (NXX) Assignment Request to the Pooling Administrator (PA) for the assignment of NXX resources which it contends are necessary because it does not have the numbers available in its current inventory in the Mount Pleasant rate center to meet a customer's request. The PA denied SBC Texas' request based on the grounds that SBC Texas did not meet the month-to-exhaust and utilization criteria established by the Federal Communications Commission. SBC Texas seeks a waiver of the Pooling Administrator's denial of its request for additional numbering resources.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than September 17, 2004. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30089.

TRD-200405339
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 23, 2004

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Notice of Application for Waiver of Denial of Request for NXX Code

Notice is given to the public of the filing with the Public Utility Commission of Texas an application on August 18, 2004, for waiver of denial by the North American Numbering Plan Administrator (NANPA) Pooling Administrator (PA) of Southwestern Bell Telephone, L.P.'s, doing business as SBC Texas, request for NXX codes.

Docket Title and Number: Application of Southwestern Bell Telephone, L.P., doing business as SBC Texas, for Waiver of NeuStar, Incorporated Denial of NXX Code Request. Docket Number 30095.

The Application: Southwestern Bell Telephone, L.P., doing business as SBC Texas (SBC Texas), submitted a Central Office Code (NXX) Assignment Request to the Pooling Administrator (PA) for the assignment of the 713-889 code in the Houston rate center. The PA denied SBC Texas' request based on the grounds that SBC Texas did not meet the month-to- exhaust and utilization criteria established by the Federal Communications Commission. SBC Texas seeks a waiver of the Pooling Administrator's denial of its request for additional numbering resources.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than September 17, 2004. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30095.

TRD-200405340
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 23, 2004

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Notice of Application to Amend Designation as an Eligible Telecommunications Carrier Pursuant to P.U.C. Substantive Rule §26.418

Notice is given to the public of an application filed with the Public Utility Commission of Texas on August 19, 2004, for designation as an eligible telecommunications carrier (ETC) pursuant to P.U.C. Substantive Rule §26.418.

Docket Title and Number: Application of XIT Telecommunication and Technology, Incorporated to Amend its Designation as an Eligible Telecommunications Carrier (ETC) Pursuant to P.U.C. Substantive Rule §26.417. Docket Number 30098.

The Application: The company is requesting to amend its ETC designation in order to add the Boys Ranch exchange which is within the service area of Valor Telecommunications of Texas, L.P. The company holds Certificate of Operating Authority Number 50010.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than September 16, 2004. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30098.

TRD-200405363
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 24, 2004

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Notice of Application to Amend Designation as an Eligible Telecommunications Provider Pursuant to P.U.C. Substantive Rule §26.417

Notice is given to the public of an application filed with the Public Utility Commission of Texas on August 19, 2004, for designation as an eligible telecommunications provider (ETP) pursuant to P.U.C. Substantive Rule §26.417.

Docket Title and Number: Application of XIT Telecommunication and Technology, Incorporated to Amend its Designation as an Eligible Telecommunications Provider (ETP) Pursuant to P.U.C. Substantive Rule §26.417. Docket Number 30099.

The Application: The company is requesting to amend its ETP designation in order to add the Boys Ranch exchange which is within the service area of Valor Telecommunications of Texas, L.P. The Company holds Certificate of Operating Authority Number 50010.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than September 16, 2004. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30099.

TRD-200405364
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 24, 2004

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Notice of Application to Amend Designation as an Eligible Telecommunications Carrier Pursuant to P.U.C. Substantive Rule §26.418 and Designation as an Eligible Telecommunications Provider Pursuant to P.U.C. Substantive Rule §26.417

Notice is given to the public of an application filed with the Public Utility Commission of Texas on August 20, 2004, for designation as an eligible telecommunications carrier (ETC) pursuant to P.U.C. Substantive Rule §26.418, and for designation as an eligible telecommunications provider (ETP) pursuant to P.U.C. Substantive Rule §26.417.

Docket Title and Number: Application of Grande Communications Networks, Incorporated (Grande) to Amend its Designation as an Eligible Telecommunications Carrier (ETC), and to Amend its Designation as an Eligible Telecommunications Provider (ETP). Docket Number 30115.

The Application: Grande was granted ETC designation in the San Marcos exchanges. Grande now seeks designation as an ETP in the Argyle, Bartonville and Copper Canyon exchanges where Verizon is the incumbent provider, and in the exchanges of Aubrey, Krugerville, Little Elm, McKinney and Prosper where SBC is the incumbent provider. Grande holds Service Provider Certificate of Operating Authority Number 60341.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than September 23, 2004. Hearing and speech-impaired individuals with text telephones (TTY) may contact the Commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30115.

TRD-200405365
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 24, 2004

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Notice of Petition for Declaratory Order

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) a petition on August 13, 2004, for a declaratory order.

Docket Style and Number: SBC Texas' Petition for Declaratory Ruling Relating to its Obligations Pursuant to Public Utility Commission Substantive Rule §26.435(e)(3). Docket Number 30081.

The Application: The petition requests that the commission issue a declaratory order addressing SBC Texas' obligations to release wholesale billing records to 9-1-1 administrative entities.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P. O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll- free) 1-800-735-2989. All comments should reference Docket Number 30081.

TRD-200405337
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 23, 2004

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Stephen F. Austin State University

Notice of Consultant Contract Award

In compliance with the provisions of Chapter 2254, Subchapter B, Texas Government Code, Stephen F. Austin State University furnishes this notice of consultant contract award. The consultant will provide advertising and creative services for the University. The Notice of Availability was filed in the June 11, 2004 issue of the *Texas Register* (29 TexReg 5841).

The contract was awarded to AMS Production Company, 16986 N. Dallas Parkway, Dallas, Texas 75248, for an amount not to exceed $100,000.

The beginning date of the contract is July 26, 2004 and the ending date is August 31, 2005.

No documents, films, recording, or reports of intangible results will be required to be presented by the outside consultant.

For further information, please call (936) 468-4305.

TRD-200405237
R. Yvette Clark
General Counsel
Stephen F. Austin State University
Filed: August 18, 2004

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Texas A&M University, Board of Regents

Request for Proposal

The Texas A&M University System is seeking proposals from interested vendors to provide charitable trust consulting and administration services for The Texas A&M University System.

Answers to questions or concerns may be obtained by contacting:

Maria L. Robinson

Director of Financial Planning

The Texas A&M University System

Office of the Treasurer

200 Technology Way, Suite 1120

College Station, Texas 77845-3424

Or e-mail at mrobinson@tamu.edu

Proposals must be received before 5:00 p.m. on September 10, 2004

TRD-200405296
Vickie Burt Spillers
Executive Secretary to the Board
Texas A&M University, Board of Regents
Filed: August 23, 2004

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Texas Department of Transportation

Public Notice - Aviation

Pursuant to Transportation Code, §21.111, and Title 43, Texas Administrative Code, §30.209, the Texas Department of Transportation conducts public hearings to receive comments from interested parties concerning proposed approval of various aviation projects.

For information regarding actions and times for aviation public hearings, please go to the following web site:

http://www.dot.state.tx.us

Click on Aviation, click on Aviation Public Hearing. Or, contact Karon Wiedemann, Aviation Division, 150 East Riverside, Austin, Texas 78704, (512) 416-4520 or 800 68 PILOT.

TRD-200405238
Bob Jackson
Deputy General Counsel
Texas Department of Transportation
Filed: August 19, 2004

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How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 29 (2004) is cited as follows: 29 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "29 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 29 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For subscription information, see the back cover or call the Texas Register at (800) 226-7199.

Texas Administrative Code

The ***Texas Administrative Code (TAC)*** is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles (using Arabic numerals) and Parts (using Roman numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (1-800-356-6548), and West Publishing Company (1-800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15:

1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 16, April 9, July 9, and October 8, 2004). If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).

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